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PRESIDENT'S ADDRESS

Dear friends and colleagues,

Welcome to Issue 8.2 of the International Journal of Dental Hygiene. This issue marks a special occasion in my professional career, as it will be the last time I write to you in my capacity as President of the International Federation of Dental Hygiene.

This year also marks another milestone in the calendar of the IFDH. Our friends and colleagues of the British Society of Dental Hygiene and Therapy are hosting the 18th International Symposium on Dental Hygiene, July 1st to 3rd in Glasgow, UK. The theme 'Oral Health-New Concepts for the New Millennium' not only reflects oral health but also new developments in the dental hygiene field. I hope many of you are able to attend, as it is the most empowering and rewarding experience of your career. At the conference the outcome of the workshop which will be held before the meeting of the delegates from the different countries in Edinburgh will be presented. In the workshop topics like evidence based dental hygiene practice, procedures and products, the future goals of dental hygiene education, disease prevention and health promotion for primary health care, and promoting inter-professional collaboration: communication and building relations across all disciplines within health care as suggested by the WHO conference last June will be discussed.

In this issue some of the articles write about attitudes of students, from different professions and backgrounds. In the study of Kumar *et al.* it is shown that there is a significant difference between the oral hygiene behaviour and caries status of dental and medical students; the latter having more caries (DMFT 1.96) than the dental students (DMFT 1.16). Furthermore, caries status was significantly influenced by the oral hygiene behaviour. Kumar *et al.* also studied factors that effect dental caries status of medical students in Udaipur city, India. The mean decayed component among the anxious students (5.4) was almost twice that of less anxious (2.77) students. Dental anxiety was the first major contributor for having more caries followed by smoking which alone explained a variance of 7.1%.

Sharda and Shetty compared oral health knowledge, attitude and behaviour of non-medical, para-medical and medical students. The knowledge scores were significantly higher for the medical students compared with those of non-medical students. The attitude scores were significantly lower for the non-medical category compared with the other two categories and the scores were the highest among the paramedical students. The behaviour scores were significantly lower for the non-medical students than for the para-medical and the medical categories. All the scores were significantly higher for females than for the males.

Soto *et al.* show that a Dental Hygiene Student Learning Climate Survey (DHS-LCS) appears to be helpful in identifying student concerns and can be used to implement interventions to help support a healthier learning climate.

That dental hygienists do not always implement in daily practice their knowledge about patient education is shown by Rataanen *et al.*

Little use was made of various educational methods, and the dental hygienists felt that they did not have enough capabilities to use the different methods. The patient's expectations and learning were not assessed systematically. The education provided and the assessment of the need for education often focused on the professional him/herself and the standpoint of the patient empowerment was disregarded.

I certainly hope that due to the publication of this article more dental hygienists will be conscious of all the possibilities which exist in patient education and that they will have the courage to implement it. We learn by doing.

In conclusion I would like to thank you for your support. A profession is measured by its organization, activities, codes and publications. We have advanced these last years because you worked hard to realize our growth.

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