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Editorial

We need more qualitative research in oral and craniofacial sciences.

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In dentistry, as in the rest of the oral and craniofacial sciences, only a small proportion of our clinical activities are related to mortality and survival. Most of our clinical activities focus on restoring function and aesthetics. During the last years, this approach has been tempered with minimally invasive procedures, improving the comfort, reducing the duration and sometimes the cost of the procedures. But how is the quality of a treatment evaluated in terms of function and aesthetics?

When oral rehabilitation clinical cases are exposed in congresses or seminars, the quality of the photographs is simply artistic, even more so when the conference is in a fancy hotel. Most of the attendees are always impressed with the aesthetic quality of the treatment. At other times, the improvement or recovery of functionality after treatment is also sometimes shown. What we can see is that dentists (and probably the rest of the health professionals) evaluate the results of the treatment from their own perspective, as if it were their own mouth and face. Is this adequate?

In almost the entire world, and at least in great part of Chile, the patients continue being patient and very patient, demanding little and submissive to the recommendations of the professional. But things are slowly changing, they are becoming not so patient, they are more demanding and less submissive than 20 years ago. It seems that they are regaining sovereignty over their face and mouth, at least some of the patients. They are no longer patients as such, they are now users or customers, customers and not clients. However, most still remain patient and the sovereign is the dentist, a dentist who adapts to satisfying this patient in transit to becoming a customer. How has dental research responded to these changes?

Several decades ago, from the medical and social sector appeared the concept of "health related quality of life". This concept focuses on evaluating the personal well-being produced by our physical and mental health. Currently there are many instruments focused on quantitatively evaluating this concept, the vast majority correspond to scales that are relatively easy to apply.[1] In dentistry we have imported this phenomenon and we have "quality of life related to oral health", *"a multidimensional construct that reflects (among other things) people's comfort when eating, sleeping, and engaging in social interaction; their self-esteem; and their satisfaction with respect to their oral health"*. Here we also find a large number of instruments available, from those evaluating the quality of life related to oral health in general, relative to implants, in children, in

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the elderly, etc. Yes, most are scales.[2]

Another relevant change, although still very incipient, is the way in which the results of a clinical case are reported. A few years ago, the CARE Statement was published to guide how results should be presented in a case report. A relevant and novel item of this guideline is that it consults the Patient Perspective.[3] Certainly, this is not a breakthrough, but at least it puts the subject on the table. Are these changes sufficient to know the experience of patients?

A problem of quantitative research, for example, that uses scales to measure psychometric variables, is that it ends up limiting the information that the patient can give us regarding their experience in dental care. Of course, the use of scales has great advantages in terms of efficiency and coverage, that is, we can get information from many people at a relatively low cost. But cheap has a price, which in this case is that we force the patient to look with a lens that sees the reality of the phenomenon in very simple terms and with little depth. What other option do we have?

In dentistry, things are concrete, at least they appear to be, many of the variables are measurable in physical terms. In the social sciences, the situation is totally opposite, almost all are psychosocial variables that we cannot measure with physical instruments. Therefore, qualitative methods have been developed to understand the phenomenon, not to explain it. By the way, these last phenomena are issues that happen with people or between people, people like our patients, including us the dentists. Is it possible to improve dental care using qualitative methodologies?

In the last decades, technological developments have allowed the offer of dental treatment options in better conditions, faster, less painful, more aesthetic, etc. However, is this really what patients are looking for? We do not know what Chilean patients are looking for in dental care. It is important to mention that the greater number of complaints against the Superintendency of Health are related to communication problems between the patient and their dentist, human relationship issues, not "quality of treatment". It is very difficult for us to evaluate this last phenomenon using quantitative methodologies.

It is possible for patients to gain more empowerment, but this could end in a conflict with dentists, just remembering the processes of medical judicialization. We need to explore patient experiences, we need more qualitative research in oral and craniofacial sciences. This can be a tool to improve our service, to ensure that patients do not become customers, but clients.

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