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Are we wasting our time in Oral Health Related Quality of Life research?

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Abstract:*Oral health related quality of life (OHRQOL) research has been reported extensively in the literature during the recent decades. The importance given to subjective perceptions of patients has propelled decision making in dentistry towards a new direction. "Patient's preference" is considered as an important domain of evidence- based dental practice. However, the diversity of patients'/community's perceptions on oral diseases and treatments which depend on socio-cultural background and circumstantial variation in responses, questions the concept of OHRQOL. This is because of two reasons; i) There will be no global agreement on treatment for a given condition ii) The best possible treatments need not be the most satisfying treatments. The providers are subject to perplexity as to whether they are justified in providing less than the ideal in the bargain to provide the patient –preferred treatment? If there is a trade- off, then, what is the magnitude? The dilemma in applying the concept at clinician's level and policy maker's level needs to be debated. If future research on this topic will not address these basic applicability issues, the concept of OHRQOL will remain a glorified pretense*.

I. Introduction

Quality of life is a broad- ranging concept affected in a complex way by the person's physical health, psychological state, personal beliefs, social relationships and relationship to salient features of his environment.[1]This concept emerged as an important outcome for health care in the 1970s. In the contemporary health care delivery and evaluation, the period from the 90s may well be called the "Quality of life" era as fewer topics have become as widely talked about in the recent times.[2]

A key element of health- related quality of life is self- perception rather than observation or measurement by another person. Every person or subject has his own self- being and his own personal world, the content of which is highly individualistic, consisting of unrepeatable reality of personal experiences and meanings. It is of particular importance, then, to understand the patient's personal and unique stand-point as the individual human being- the mind- in- particular. Applying the same idea, the term oral health related quality of life (OHRQOL) has been adopted for the subjective oral health status. The measures of OHRQOL have been assumed to be socio-dental indicators.[3] However, these measures and the concept itself suffers from an embarrassing richness of possibilities. For instance, what kind of circumstances providesgood conditions to live and where does dental health find its place? For example, how much are we sure that edentulism most of the time affects most of the people in the same manner with the same impact on their lives? The argument here is not to understate the importance of prosthetic modalities but is that how well thenormative clinical benefit is perceived consistently by the beneficiaries.Another complexity is that the patriarchal dentist- patient relationship and the "I know what is good for you" attitude of health providers cannot be criticized. In the lesser educated sections of society, the patient may not see the seriousness of a pre-cancerous lesion and not perceive the effect of advice/treatment useful, while the dentist knows it by qualification and is ethically directed to treat the patient oblivious of the patients' perceptions.Philosophy distinguishes three broad kinds of theories that explain what is good for the individual- hedonist,idealist and preference satisfaction theories.[4]A dentist who is a hedonist will consider that the ultimate good for his patient would be ability of his patient to undergo conscious experiences characterized as pleasure and happiness by virtue of the treatment. A dentist who is an idealist is one who would defend that a good life for the patient consists of realization of specific, explicit normative ideals and results. Dentists who support the preference satisfaction theory will defend that good outcome is something that matches the preferences of the patient and that which satisfies him.

As we move from bench to applied science and patient-centered approaches to measure treatment needs and efficacy of care,we shouldknow if the concept ofOHRQOLis a practically valid concept or falsely over-emphasized. Is the recent importance on subjective perceptions, escapism to the pervasive problem of low oral health-care utilization, unsatisfactory outcomes and poor oral health? Isit a rescue operation to save the face of the sinking popular models of health education viz. the Health belief modelby victimizing subjective

perceptions?Is it a justification to unequal access to oral health care? Are we wasting our time inoral health related quality of life research?

Are we concluding that the overwhelming research visible in therecent decades on the subject is a joke?Probably not, if we see that OHRQOL has a role in clinical dentistry which translates into the clinicians' recognition that they do not treat teeth and gums, but human beings. In fact, the extensive research on this topic has led to the upbeat of positive vibrationsat various levels of oral health care.

At the individual level, the concept of OHRQOL has undoubtedly made clinicians realize the importance of patients' priorities and options in deciding the treatment needs. In his pursuit to deliver the best treatment modality through evidence- based dental practice, apart from expertise and review of existing literature, the dentist of today is in need to accommodate patient's needs as well.[5]

At the community level, the concept of OHRQOL is very important to promote oral health and access to care through advocacy. For example, a clinical dental indicator such as decayed, missing and filled teeth (DMFT) is not a suitable tool for advocacy at the political level because it was designed mainly to measure the severity and prevalence of caries but not the brunt of that magnitude on an individual's daily life and general health.In contrast, policy makers may appreciate the impact of caries when high DMFT scores are interpreted in terms of impaired quality of life because of inability to eat, sleep or concentrate because of the associated pain. In this sense, OHRQOL is a better tool to communicate with policy-makers and negotiate access to care.

OHRQOLresearch has focused to a large extent on psychometric properties of various generic and specific measures[3,6-8] and on comparisons of treatment modalities based on patient-centered outcomes.[9-11] However, there is still a dearth of research that is yet toreveal sharper images of how OHRQOL is described in different populations. Once this is clarified, it might be easier to devise interventions perhaps borrowing from similar groups experiencing success in the improvement of OHRQOL. Application of such research will then be possible through skillfulconversion of the results into a database of patient preferences.Results of research should translate to superior outcomes based on patient- driven dentistry. The research volume on this concept canonly then bejustified.

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