

Patient satisfaction and quality of emergency dental care in Chilean public health services.

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Abstract: The provision of dental care services, related to the quality requirements of health policies and patient satisfaction rates, increasingly requires the creation of qualitative indicators, instruments and criteria based on specific objectives, to validate the quality of the services provided. objective: The aim of this study is to determine the main dimensions of the dentist-patient relationship associated with patient satisfaction in a clinical context, with emphasis on the needs and expectations of patients themselves. method: A sample of 88 adults who attend primary care units at public emergency services in the central area of Chile were studied using a qualitative approach based on the Social Psychology of Health and on Grounded Theory. From these, categories emerged that identify processes, attitudes and behaviors that define the assessment of care providers based on their practices. results: In an interactional context characterized by the patient's expectation regarding the provision of care and anxiety due to potential pain, two already recognized main axes emerged, namely: the capacity to generate trust through interpersonal and communicative good treatment strategies, and the capacity or technical skills of the professional care provider. conclusion: This study proposes a protocol of good care practices, which takes into account the needs and expectations of patients regarding the role of the dentist.

Keywords: *dentist-patient relationship; patient satisfaction; dental care; quality of health care; patient comfort.*

INTRODUCTION.

Policies aimed at improving the quality of health care services have been increasingly promoted by the Chilean Ministry of Health based on ethical criteria and social responsibility. Like in many Western countries, the Chilean state seeks to guarantee access to health care, improve patients' satisfaction and trust in the system, optimize resources and improve the quality and comfort of the services, including the provision of dental care.¹ In this context, dental health is redefined according to socio-cultural and psychosocial characteristics, which seek to reposition it in the communities, taking into account social determinants of health, vulnerability, and equity. All this with a focus on the patients, including their participation in decision-making, their autonomy and subjective cultural definitions of oral health.² The World Dental Federation (WDF) discusses the role of the dentist in this new scenario proposing a change from one that "treats the disease" to one that "provides care and support for the oral health of patients."³ This new approach challenges dental research in broadening the biomedical orientation to strengthen, for example, the patient-dentist relationship, since it could determine the opportunities

for both to produce these changes. In this context, the dental clinic is considered a space for dialogue where the subjective and qualitative nature of the disease-health and dental-care process emerges, strongly influenced by the social and cultural environment.

Although the explicit role of the patient is part of the emerging approaches in dentistry, previous studies conducted on patient satisfaction and others focused on communication⁴ or on the patient themselves.⁵ Regarding the former, patient satisfaction is defined as the measure in which the needs and expectations of the patients are met, both in terms of the technical capacity to solve their problems, and subjectively in terms of their approval of the service.

At an international level, several prevalent quantitative models are used to determine the quality of care, such as: SERVPERF or Service Performance; the Cano Model; the *Jefferson Scale of Physician Empathy CAT* (communication assessment tool),⁶ among others. They group, in varying degrees, dimensions related to the evaluation of the dentist-patient relationship: a) communication-information: taking questions from the patient, listening and providing answers, time taken to explain; b) social skills: empathy, concern for the other person, ethics, courtesy, kindness; c) socio-affective environment: respect, reliability, confidence, management of anxiety, and time spent with patients.⁷⁻¹⁰ Within the framework of these indicators and mainly based on the social determinants of health, most of these studies show high patient satisfaction, while simultaneously revealing different realities.

Within a Chilean context, studies have primarily been carried out on the quality of the services in relation to equity,¹¹ local idiosyncrasy,¹² bioethical issues,¹³ and the training of dentists.¹⁴ Of particular interest are those that aim to contextualize dental care satisfaction with respect to more specific aspects, such as the ability of professionals to recognize errors,⁷ communication,⁸ management of patient's anxiety in the face of pain,⁹ or patient's participation and involvement.¹⁵

Among these problems, the management of fear and anxiety related to dental pain has been studied by Armifield,¹⁶ Berggren *et al.*,¹⁷ and Kleinknecht *et al.*,¹⁸ as it interferes with the quality of the patient-dentist clinical relationship. Fear constitutes an emotional response associated with stress and anxiety caused by a subjective

danger that can trigger the response of the nervous system;¹⁹ and, to a lesser extent, phobias, which correspond to a more specific reaction associated with the anticipation of an aversive event.²⁰ In this context and regarding care strategies, the socio-affective skills of the dentist play a significant role, since the expectation of potential pain involved in the intervention or related to the patient's previous bad experiences could trigger the patient's refusal of treatment. The patient's perceptions of care is thus affected by the technical and empathy skills of the dentist, particularly in relation to pain and anxiety management.⁹ In the doctor-patient relationship, besides contributing to diagnosis, these skills would improve motivation and encourage the patient's participation, thus increasing patient satisfaction.¹⁵

In any case, patient satisfaction studies emphasize the importance of inter-personal skills, the ability to give and receive information and to generate positive environments for patient-dentist communication. There is consensus that the greatest challenges are to favor patient participation and the development of professional inter-personal and psychosocial skills, especially in comprehensive care approaches.^{7,10,14,21-23}

However, despite current and conventional evidence¹⁹ regarding the importance of psychosocial aspects on the quality of dental care, its impact on dentistry programs in Chile is low,¹⁴ restricted to quantitative studies, and still under development in the rest of the world.⁵ Although advances have been made in studies associated with the development of public services and patient satisfaction, through surveys at national level regarding the treatment provided by administrative staff and the quality of care delivered by the professional team, they do not seem sufficient and are not in agreement regarding the definition or measurements of quality of the oral health care services.² The search for data and qualitative indicators of patient satisfaction, associated with the quality of health services, emerged in the 1990s - particularly in Europe - with the notion of good treatment as part of a good practices approach associated with social responsibility and ethics within various services. This is especially true in the case of vulnerable populations, as necessary in contexts in which understanding and legitimizing the other individual are essential.²⁴

The challenge of having references to develop protocols from, which will improve the quality of care, is even greater when it comes to public health research. Chile has a lower production in this area than its peers from the IADR (*International Association of Dental Research*), and even fewer studies based on qualitative approaches.²⁵

Faced with the contextual complexity and subjectivity involved in the dentist-patient interaction regarding the problem of the quality of dental care, unveiled in the aforementioned studies, the present research work adopts the interdisciplinary orientation approach based on the social psychology of health.²⁶ This approach goes beyond the classic dichotomy between macro-social and individual determinants, analyzing the influence of the social context, in the understanding that it is here where the structural determinants and sociocultural dimensions that also affect health are present. In this way, patient satisfaction would integrate the processes of interaction between all actors with the recognition of significant practices that mobilize predispositions and subjective attitudes and, at the same time, structuring realities as concrete as the achievement of a well performed treatment.

For this reason, this study aims to determine the main dimensions involved in the dentist-patient relationship associated with patient satisfaction in a clinical context, with emphasis on the needs and expectations of the patients themselves.

MATERIALS AND METHODS.

The qualitative methodological design used in this study included flexible principles and procedures of the Grounded Theory²⁷ to understand patient satisfaction from a substantive empirical base, under the rationale of the researchers wanting to broaden the biomedical view in public health, so that dental health services adapt equitably to the sociocultural diversity of the vulnerable epidemiological population under study. Qualitative methods based on semi-structured interviews were used because they favor in-depth exploration of complex phenomena from the experience of the actors themselves, and contextualized in their own fields of action. In addition, the qualitative methodology based on the Grounded Theory makes the methodological design more flexible in function of the common problems that emerge from the experience of the

participants, thus allowing a holistic and grounded view of the problems under study.

Sample: The methodological strategy involved a convenience sample of 88 adults between the ages of 21-63 years (Table 1) (without rejection or dropout) recruited face to face in the waiting rooms of dental emergency services (selection criteria) at Family Health Centers (CESFAM, for their acronym in Spanish), strategically selected, where dental interns of Universidad de Talca complete their professional training. The following districts were included: a) Paredones, semi-rural, with a poverty rate of 33.41% by income, according to the 2013 National Socioeconomic Characterization Survey (CASEN, for its acronym in Spanish); b) Rengo, semi-rural, with 20.47% of the population living in poverty (by income), and; c) the Carlos Trupp neighborhood in the city of Talca,²⁸ a vulnerable urban area, consisting of a socially emerging population. These districts are characterized by informal and sporadic sources of work, minimum income, and a population with incomplete primary and secondary education. The rural population is also associated with low income and low educational levels, so the risk of oral disease is higher. This marks a difference in the access to health care, mainly due to poor access to information, such as delayed dental visits and limited resources.^{12,29}

Data collection technique: Qualitative semi-structured interviews (Table 2) - 40 to 90 minutes each, digitally recorded - were carried out by dental nurses (trained by the principal investigator, and without a prior relationship with the interviewees) at CESFAMs or at patients' homes, in exploratory phases, empirical saturation and triangulation, between August and December of 2014-2017. Interviews were kept anonymous and private. Informed consent was obtained and forms safely kept in the premises of the Department of Public Health at Universidad de Talca.

Analysis and results: Coding was applied -with Nvivo10- open, axial and selective; and the frequency analysis plotted in the coding tree (Table 3) and in the logical model (Figure 1). The intra-method triangulation by time, scenarios, subjects and researchers, took place between November-December 2014-2017, at the three CESFAMs, with 24 interviews carried out by the members of the research team. All this contributed to the reliability to the study.

Figure 1. Good treatment protocol for dental care.

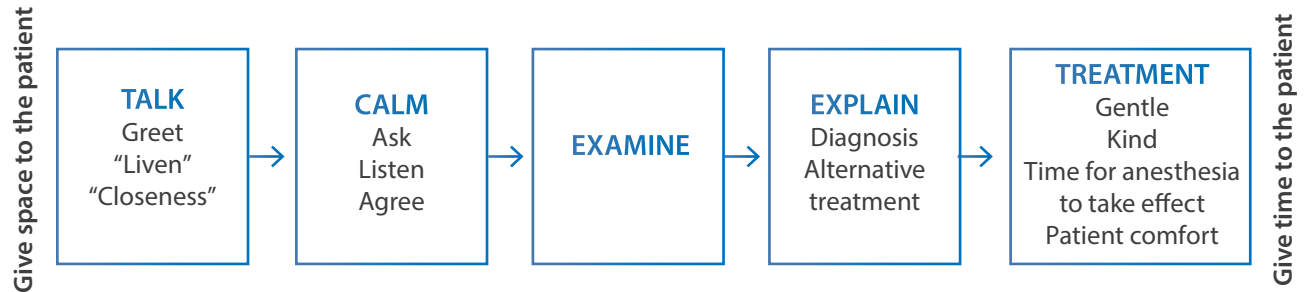


Table 1. Biodemographic description of the participants.

	Characteristic	Frequency N=88	Percentage (%)
Districts	Rengo	20	23
	Paredones	24	27
	Talca (<i>Carlos Trupp neighborhood</i>)	44	50
Age	≤ 25	20	22
	25-34	16	18
	35-44	26	29
	45-54	22	25
	55-64	5	6
Sex	Female	66	74
	Male	23	26
Place of residence	Urban	50	56
	Rural	39	44
Educational level	Primary-incomplete	5	6
	Primary-complete	27	30
	Secondary-complete	51	57
	University/technical	6	7

Table 2. Summary of Qualitative Interview Protocol .

Interviewer introduction: Good afternoon, we are and we are studying how people deal with tooth pain and how they take care of their dental health. The objective is to be able to understand what you have to go through and identify the main problems you have. For that reason, we need people like you who are willing to share their experiences by means of an interview.

Procedural explanations: The interview is a 60-minute conversation and consists of a series of questions about your experience. This will be recorded but your name will not be revealed. You will be asked to sign a document through which Universidad de Talca takes full responsibility for the research. Would you like to participate in this study by agreeing to be interviewed? (Reading and signing of informed consent, start of recording).

Starting question: Could you share with me how you have experienced and managed your dental health problems since you first began to feel discomfort until now?

ESSENTIAL AREAS*	SUB-AREAS	
HEALTH STATUS	General health status oral health status	Interpretation of symptoms (semantics) care decisions, practices
LANDMARKS IN TRAJECTORY OF CARE	Trajectory, decisions access to health care	Influences, support networks, pain
HEALTH CARE	Experience	Relationship with staff quality of care
LIVING CONDITIONS	Living conditions risk and protective factors	Social determinants self-care routine
VISION AND EXPECTATION	Health status health care	Lifestyles, health system quality of professionals

*Essential contents are included in all interviews regardless of the adaptations to the guidelines.

Table 3 Prevalence of categories and subcategories constructed according to positive or negative assessment of dental care experience.

Dental care experience		Number of interviews (n=88) Assessments	
		Positive (%)	Negative (%)
CATEGORY "TREATMENT"		72.7	56.8
Sub-categories	Personal qualities of the professional	42.0	26.1
	Relational strategies	40.9	36.4
	Consequences of the quality of treatment	38.6	35.2
	Associated conditions	35.2	35.2
CATEGORY "COMPETENCY"*		53.4	29.5

* No substantive subcategories are found in the "competency" category.

Table 4 Dichotomous descriptors by categories and subcategories.

Categories	Good treatment* Descriptors	Bad treatment* Descriptors
Personal qualities	"friendly", "warm", "affectionate", "patient", "loving", "closeness", "nice", "good sense of humor",	"cold", "unfriendly", "grumpy" "bad-tempered", "indifferent"
Relational strategies	"initiates conversation", "tell jokes", "entertains", "distracts" "asks questions", "listens", "explains" "treats everyone equally"	"does not explain", "does not talk", "scolds" "tells people off", "criticizes", "only talks with each other staff" "does not even look at the patient... (to see if it hurts)"
Consequences of the quality of the treatment	Atmosphere full of "confidence", "peacefulness", "it hurts less, "let me tell you", "let me ask you"	"It hurts even more", "bad experience", "fear"
Associated conditions	Focused on the patient's well-being: Give and take personal space and time.	Focused on profit "Starts work immediately", "Does only his/her job", "is only interested in money", "always in a hurry",
Skillful/ unskilled	"Careful", "meticulous" "does his/her job well" offers alternative treatments options	"Rude", "in a hurry"

RESULTS.

The main results of the study show that the attributes of satisfactory dental care are defined by the dentist's ability to alleviate anxiety in the face of dental pain, providing the patient with socio-affective support, time and space. Second, quality care is associated with a technically competent dental professional. Patients expect to find a professional "concerned about their patients" and able to create a suitable socio-affective environment, so that patients are also able to express their fears and apprehensions. This allows patients to communicate their needs and agree on mechanisms to give them some

control over painful procedures.

A significant number of interviewees appreciate dentists who "use psychology" to alleviate anxiety related to pain. These are dentists who purposefully distract patients with enjoyable conversation in order to reduce their anxiety. Patients report to feel that the dentist has "prepared them" for treatment talking about colloquial topics, such as family, their children, etc., thus making patients "forget" "where they are". They define them as warm professionals, who can "tell jokes", who are not "boring" and "not so robot-like".

The main subcategories associated with good and bad

treatment in the patient-dentist relationship related to emic descriptors are outlined below. They also include the expressions used by the interviewees (Table 4).

Good dentists are also described as "close" or empathic, committed professionals, who see their patients as persons. They provide affective support by treating their patients with kindness and patience to calm them down, to assure them their pain will soon be gone; they ask them where it hurts or if their pain has been relieved; that they will not have to go through that again. In short, patients describe these types of dentists as people who understand and legitimize their fear of pain.

The relational skills of the dentist, which the great majority of the interviewees identify as "good treatment" or "closeness", is associated with personal qualities of kindness. Likewise, these dentists are characterized as "loving", "affectionate", "close", "nice" and "human" individuals. They are also described as friendly and in a good mood.

Relational skills related to good treatment are actualized in concrete actions during the care process, sequenced in the following order: call the patient by his/her name, greet, ask, talk, explain, make sure that the patient is comfortable before and during treatment, and do a follow-up.

With respect to the expectations of patients regarding the ideal form of communication, it was observed that it was important for the patient that dentists dedicate appropriate time to the delivery of information before the procedure and "not as I proceed with the treatment". The same refers to explanations about the procedures, which are expected to be made prior to their execution. In general, the expected form of communication is clear, simple and detailed; supported by concrete evidence, in situ; ideally with evidence that allows specifying, naming and showing each of the procedures and processes involved.

In this context of communication and good treatment, regarding the information the patient expects to receive, we have primarily identified the following: naming the patient's health problems and their causes, including those that are the patient's responsibility; treatment steps and possible results; describing the actions that the patient must take for self-care, ideally in writing;

knowing how to give "bad news" such as the extension or level of difficulty of the required treatments; and, in the face of pain, the dentist should do their best to avoid patient's discomfort. That is, trying to explain using the patient's own language, "what I have", "what it is about" and "how I have to deal with it".

In contrast, patients with negative experiences describe the dentist as a person who "mistreats" their patients. This mistreatment ranges from a dentist who is defined as distant, to one who physically and psychologically harms the patient, causing traumas and leading to the future avoidance of dental care.

Mistreatment, according to patients' reports, would occur due to the lack of relational and technical skills. Some dentists create an atmosphere of distrust that stresses the relationship with their patients. According to the experiences reported by the interviewees some care providers: "do not greet", "do not ask", "do not talk", "just do their job," "scold", "reprimand" or "criticize". These actions depersonalize the attention and some patients describe these dentists as "unkind" or "not friendly", that is, the type you do not talk to, you do not ask any questions, you do not confess your fear of pain, and you do not expect them to have any consideration for you as a patient.

Interviewees frequently associate poor dental care with dentists "who just do their job", who would be more interested in making a profit than in their own calling and ethical concern for the wellbeing of their patients. They are described as professionals who "are always in a hurry", and this would explain why they do not interact with their patients and why they are described as "unkind". Although a few interviewees associate this attitude with the poor working conditions of dentists at the CESFAM, this does not appear to justify their bad attitude towards their patients.

Quality care is associated secondarily with the quality of the therapeutic relationship with the competent professional. Although for some this professional is the one who performs the appropriate diagnoses and treatments, the indicator of performing a "careful" work during the whole procedure, without causing anxiety or pain for the patient, is very relevant. This competent dentist not only takes the necessary time to do their

job well, but also offers patients time and space to ensure their comfort, specifically, for example, "for the anesthesia to take effect" or to request more anesthesia -before or during treatments. They also give patients time to rest or "close their mouth;" to rinse and/or relax and "talk".

Professional competence is also associated with ethics, as a necessary quality of care, specifically related to the professional's ability to take into consideration the human condition of the patient, without discrimination; and to separate their personal problems from their professional performance.

The competent professional is also one who "has the answers", who "checks everything", one prepared to face difficulties, to perform a clinical examination, who "does it well", and ensures a good result, one that offers alternative treatment options, "demonstrates confidence in what they do", knows "when to recognize their mistakes", takes care of their patients. It is defined in opposition to the bad dentist, described as "rough" or "unkind", who shows no interest in preventing discomfort or pain in their patients, with whom patients prefer to remain silent, endure the pain and avoid seeing these dentists again.

To conclude, it is possible to propose a protocol of good care practices focused on patient satisfaction taking into account the needs and expectations of patients regarding the role of the dentist (Figure 1).

DISCUSSION.

This study aims to determine the main dimensions of the dentist-patient relationship associated with patient satisfaction in a clinical context with emphasis on the needs and expectations of people who attend public emergency dental services in primary care.

Results indicate that good quality of dental care is associated with the dentist who shows and genuinely develops communicative strategies that "enliven" the relationship with their patients, so that people feel they are in a warm and "personalized" environment.

This relaxed and social atmosphere helps to reduce anxiety related to pain by giving patients, the dentist and the treatment itself, time and space. Therefore, results of international studies that associate the expectations of the

quality of care with relief of anxiety in the face of dental pain and the invasive nature of treatments have been confirmed.^{8,9,30}

In the same way, the findings support the importance of the socio-affective and communicative dimensions for the quality of dental care, which converge on these major categories: quality of treatment, relief of anxiety and pain, communication, technical quality of care, interpersonal and personal qualities of the professional and technical competence.^{4,5,7,8,30}

The contribution of the present study is that it is actually based on the construction of meanings by the patients themselves, the importance of quality care, which is defined in this study as a cultural aspect associated with the dentist as a "close person". They coincide, from this perspective, with the findings reported in quantitative studies, particularly those that emphasize the importance of communication skills,^{6,23,24} emphasizing, in the present case, the relevance of "explanation" over information. According to the results, the latter is associated with inclusive relational strategies that allow the patient to have a proactive behavior regarding their own comfort during the treatments, among others. The explanation is presented as a synergistic relational strategy that accompanies the whole process or treatment, or as a dialogic attitude that welcomes and accepts the other person, favoring the regulation of the patient's anxiety. It also implies the recognition of the other by the dentist and gives the patient the opportunity to express them self.

One the limitations of the study is that the research was focused on the patients' definitions of the quality of dental care without disaggregating by social determinants of the participants or the dentists. Convenience sampling is another relevant limitation of the study, as it is valid only for the population of the country and area in which the study was conducted. The results are representative of patients who generally visit the dentist for emergencies, which could differentiate their vision of patient satisfaction from those who undergo longer treatments and therefore establish another type of relationship with their dentists. It is also typical of the sample that they seek treatment in public service because it is free, therefore it can be inferred that they do not have the means to choose specific professionals nor have access to private health care. It is

also suggested to conduct studies that help determine patients' access to care and the degree to which previous dental health experiences could influence their vision of the quality of care.

The definition of new operational interaction models that favor mutual involvement and commitment to treatment and prevention will improve the specific guidelines for

providing appropriate treatment in the clinic and the training guides for dental students. They will contribute to the improvement of care, services, indicators and to the welfare of the population.

To conclude a protocol of good care practices is proposed that takes into account the needs and expectations of patients regarding the role of the dentist.

REFERENCES.

1. Ministerio de Salud (MINSAL); División de Rectoría y Regulación Sanitaria, Departamento de Epidemiología. *Objetivos Sanitarios para la Década 2000- 2010. Evaluación a mitad del período.* 1st Ed. Santiago, Chile: Gobierno de Chile; 2002.
2. Lee JY, Watt RG, Williams DM, Giannobile WV. A New Definition for Oral Health: Implications for Clinical Practice, Policy, and Research. *J Dent Res.* 2017;96(2):125–7.
3. Glick M, Williams DM, Kleinman DV, Vujicic M, Watt RG, Weyant RJ. A new definition for oral health developed by the FDI World Dental Federation opens the door to a universal definition of oral health. *J Am Dent Assoc.* 2016;147(12):915–7.
4. Street RL Jr, Makoul G, Arora NK, Epstein RM. How does communication heal? Pathways linking clinician-patient communication to health outcomes. *Patient Educ Couns.* 2009;74(3):295–301.
5. Mills I, Frost J, Moles DR, Kay E. Patient-centred care in general dental practice: sound sense or soundbite? *Br Dent J.* 2013;215(2):81–5.
6. Waylen A, Makoul G, Albeyatti Y. Patient-clinician communication in a dental setting: a pilot study. *Br Dent J.* 2015;218(10):585–8.
7. Raja S, Rajagopalan CF, Patel J, Van Kanegan K. Teaching dental students about patient communication following an adverse event: a pilot educational module. *J Dent Educ.* 2014;78(5):757–62.
8. Armfield JM, Enkling N, Wolf CA, Ramseier CA. Dental fear and satisfaction with dental services in Switzerland. *J Public Health Dent.* 2014;74(1):57–63.
9. Wilson K, Bouchiba M, Vithlani G, Holmes R. Patient satisfaction with oral urgent treatment (OUT) in North West Tanzania. *Br Dent J.* 2013;215(3):131–4.
10. Goetz K, Szecsenyi J, Klingenberg A, Brodowski M, Wensing N, Campbell SM. Evaluation of patient perspective on quality of oral health care in Germany--an exploratory study. *Int Dent J.* 2013;63(6):317–23.
11. Gallego F, Larroulet C, Palomer L, Repetto A, Verdugo D. Socioeconomic inequalities in self-perceived oral health among adults in Chile. *Int J Equity Health.* 2017;16(1):23.
12. Quinteros ME, Cáceres DD, Soto A, Mariño RJ, Giacaman RA. Caries experience and use of dental services in rural and urban adults and older adults from central Chile. *Int Dent J.* 2014;64(5):260–8.
13. Portela León FJ. Caracterización de los aspectos bioéticos en los reclamos realizados ante la Superintendencia de Salud de Chile en el área de odontología. *Acta Bioeth.* 2013;19(1):143–52.
14. Espinoza L. Training instances related to health psychology and counseling in the curricula of Chilean dentistry. *J Oral Res.* 2016;5(2):77–81.
15. Lucander H. An Instrument to Assess Dental Students' Competence in Shared Decision Making: A Pilot Study. *J Dent Educ.* 2017;81(12):1463–71.
16. Armfield JM. How do we measure dental fear and what are we measuring anyway? *Oral Health Prev Dent.* 2010;8(2):107–15.
17. Berggren U, Meynert G. Dental fear and avoidance: causes, symptoms, and consequences. *J Am Dent Assoc.* 1984;109(2):247–51.
18. Kleinknecht RA, Klepac RK, Alexander LD. Origins and characteristics of fear of dentistry. *J Am Dent Assoc.* 1973;86(4):842–8.
19. Feitosa S, Colares V, Pinkham J. The psychosocial effects of severe caries in 4-year-old children in Recife, Pernambuco, Brazil. *Cad Saúde Pública.* 2005;21(5):1550–56.
20. Ríos Erazo M, Herrera Ronda A, Rojas Alcayaga G. Ansiedad dental: Evaluación y tratamiento. *Av Odontostomatol.* 2014;30(1):39–46.
21. Carter AE, Carter G, Boschen M, AlShwaimi E, George R. Pathways of fear and anxiety in dentistry: A review. *World J Clin Cases.* 2014;2(11):642–53.
22. Loignon C, Allison P, Landry A, Richard L, Brodeur JM, Bedos C. Providing humanistic care: dentists' experiences in deprived areas. *J Dent Res.* 2010;89(9):991–5.
23. Guivarc'h M, Saliba-Serre B, Jacquot B, Le Coz P, Bukiet F. Dental students' attitudes towards management of pain and anxiety during a dental emergency: educational issues. *Int Dent J.* 2017;67(6):384–90.
24. Contreras-Ramírez R, Vega-Arce M. Buen trato a la infancia: deriva semántica en la producción científica publicada en Latinoamérica. *Entramado.* 2016;12(2):140–52.
25. Cartes-Velásquez R. Some ideas for qualitative research in oral and craniofacial sciences. *J Oral Res.* 2017;6(5):108–9.
26. Morin M, Apostolidis T. *Contexte social et santé. Traité de psychologie de la santé.* Paris, Francia: Dunod; 2002.
27. Strauss A, Corbin J. *Facultad de Enfermería de la Universidad de Antioquia. Bases de la investigación cualitativa. Técnicas y procedimientos para desarrollar la teoría fundamentada.* 1st Ed. Colombia: Imprenta Universidad de Antioquia; 2002.
28. Biblioteca del Congreso Nacional de Chile (BCN) Reportes Estadísticos Comunales. Santiago, Chile: BCN; 2015.
29. Urzua I, Mendoza C, Arteaga O, Rodríguez G, Cabello R, Faleiros S, Carvajal P, Muñoz A, Espinoza I, Aranda W, Gamonal J. Dental caries prevalence and tooth loss in Chilean adult population: first national dental examination survey. *Int J Dent.* 2012;2012:810170.
30. Orsini CA, Jerez OM. Establishing a good dentist-patient relationship: skills defined from the dental faculty perspective. *J Dent Educ.* 2014;78(10):1405–15.