

Published in Psychology, Health & Medicine

<https://doi.org/10.1080/13548506.2018.1457167>

'You have to treat the person, not the mouth only':

UK dentists' perceptions of communication in patient consultations

Running title: Dentist-patient communication

Marta Justyna Nowak BSc (Hons), MSc

Heather Buchanan, BA (Hons), MSc, PhD

Division of Rehabilitation and Ageing

School of Medicine

Queen's Medical Centre

University of Nottingham

Nottingham NG7 2UH

Tel: 0115 8467520

Koula Asimakopoulou, BSc (Hons), MSc, PhD

King's College London

Dental Institute

Division of Population and Patient Health

Social and Behavioural Sciences Group

Floor 18, Tower Wing, Guy's Hospital

London SE1 9RW

Corresponding author: Marta Justyna Nowak

E-mail : mj_nowak88@yahoo.co.uk

Abstract

Effective communication between patients and health professionals is a key component of patient-centred care. Although there is a large body of literature focusing on doctor-patient communication, there has been limited research related to dentist-patient communication, especially presented from the dentists' perspective. The aim of our study was to explore UK dentists' perceptions of communication in their consultations, and the factors they perceive may influence this. We conducted semi-structured interviews with eight dentists in UK dental NHS practices. Thematic analysis revealed three themes ('Treating the whole person', 'Barriers to patient-centred communication' and 'Mutuality of communication'), which reflected the dentists' perceptions of their own communication during consultations, the patients' interaction skills, attitudes (and characteristics that may affect them), and external factors, such as time constraints, that can influence dentist-patients' encounters. These in-depth accounts are valuable, in that we see what dentists perceive is important, obstructive and facilitative. They report using a patient-centred approach in their everyday dental practice; however this is often difficult due to factors such as time constraints. Although they emphasized that the patient has an active role to play in the communication process, it may be the case that they also need to play their part in facilitating this.

Introduction

Models put forward both in medicine (Mead & Bower, 2002; Mead & Bower, 2000; Stewart et al, 2003) and in dentistry (Scrambler & Asimakopoulou, 2014; Asimakopoulou, 2015) advocate the delivery of patient-centred-care (PCC). Although different, these models rest on the assumption that for PCC to occur in practice, dentists and patients have to be able to engage in effective communication. Effective communication leads to enhanced treatment outcomes, adherence to medical advice, a better practitioner-patient relationship, fewer treatment mistakes and higher satisfaction (Hallm, Roter & Katz, 1988; Kaplan, Greenfield & Ware, 1989; Woelber et al, 2012).

Street (2003) developed an ecological model of communication in medical encounters describing how participants and external factors (e.g. media) interact to affect the level and quality of communication. High levels of mutuality, where one person can influence the other (Street, 1991; Street, 2002; Street, 1992) can help, although, it is suggested that the practitioner will act as a facilitator of this inter-personal relationship, enabling the patient-physician encounter to serve its actual purpose (Ong et al, 1995; Roter & Hall, 1992).

Dentist-patient communication

Whilst a large body of literature has focused on doctor-patient communication, dentist-patient communication remains largely unexplored. This is surprising, as applying findings from the medical context to the dental environment may be misleading given the differences between settings (Sondell, Söderfeldt & Palmqvist, 2003). Studies exploring dentist-patient communication have examined the patient's perspective of the consultation and satisfaction with dentists' communication skills (Milgrom et al, 1996; Williams & Calman, 1991) or dental phobia (Kulich, Berggren & Hallberg, 2003; Berson et al, 2011). Research exploring dentists' perception of their patients' verbal and non-verbal behaviours has been relatively scarce. Rouse & Hamilton (1991) found that US dentists rated their patients according to their interpersonal responsiveness (positive behaviour towards a dentist), perceived compliance and tractability (e.g., cooperativeness). Indeed, dentists considered patient compliance as the most preferable, helpful characteristic in interactions, across a number of studies (Milgrom et al, 1996; Brennan & Spencer, 2006).

PCC and Dentist-patient communication

Research on dentists' beliefs about, and experience of facilitating PCC in oral health settings (Scambler, Gupta & Asimakopoulou, 2014) showed that dentists generally value PCC and believe in facilitating it in practice. Despite not having been formally taught how to facilitate PCC, they feel the ability to be patient-centred comes naturally to most

dentists. Similarly, giving patients choice was seen as a central feature of PCC, although the type of choices made available to patients was generally determined by the clinician who made a judgment on what was “best” for the patient. In the same study PCC was used as a tool by which clinicians could support patient compliance.

Given the importance of PCC and effective communication in delivering oral healthcare, our study provides an in-depth exploration of dentists’ own perceptions of communication in consultations, and factors they perceive may influence this. A holistic approach, trying to explore more generally the dentists’ views and perceptions through their own experiences is used, to explore how dentists perceive they communicate with patients and their experience of dentist-patient communication.

2. Methods

Participants

Participants were recruited from the UK NHS directory for the Midlands (England). A purposive sample of 25 dentists (minimum 2 years working as a dentist) was contacted; 10 declined to participate (citing lack of time) or did not respond. Fifteen dentists were initially recruited. As saturation of data was achieved after 8 participants, this comprised the final sample. Participants comprised 5 females and 3 males, mean age 32.4 years (range=25-53 years) with 2-28 years experience in dentistry

(mean=8 years). All were self-employed associates working in NHS dental practices.

Materials

A semi-structured interview schedule based on issues raised in the wider patient-practitioner research literature, explored i) dentist-patient communication/relationship generally, and ii) factors (e.g., context, personal characteristics) that might reasonably be thought to influence communication. These included: (1) the dentists' self-perceived communication skills including their awareness of PCC models of communication and the extent to which they applied such models to their own dental practice (2) perceptions of their patients' attitudes, behaviour and communication skills including information seeking skills and understanding, autonomy in the decision-making process, responsibilities and stereotypes.

Procedure

The study was approved by MN's University ethics committee (Reference: RP/12.13/HBMN). Pilot interviews were conducted with two participants and minor adjustments made to the interview schedule. MN conducted all interviews in accordance with British Psychological Society ethical guidelines. Interviews (average length 35 mins) were audio-recorded and transcribed verbatim.

Data analysis

An inductive thematic analysis was conducted, where identified themes were strongly associated with the data (Patton, 1990). Thematic analysis was selected as it shows similarities as well as differences in the data, and is regarded as a flexible method of analysis (Braun & Clarke, 2006). A standard process of familiarisation, coding and theme generation was followed.

3. Results

Analysis identified 3 main themes and 8 sub-themes reflecting dentists' perceptions of their interactions with the patients as well as patients' communication and factors influencing them (Table 1). Codes in brackets reflect the participant's gender and participant number (reference to gender for notation only).

Treating the 'whole' person

Although none of the interviewees had explicitly heard of a patient-centred model of communication, all claimed they employed PCC, at least to some extent, in their everyday practice. They emphasized the importance of treating patients as individuals, by altering their communication style to fit each patient whilst following standard

procedures. An attempt to understand the patient and to treat them 'holistically' was prevalent:

"So you have to treat the person, not the mouth only. (...)" (F1)

It was commonly stated that patients were encouraged to lead the conversation by being prompted to express themselves without interruption. The dentists were reportedly able to obtain a deeper understanding of their patients' needs, expectations and personality.

Building rapport

All dentists rated their own communication skills positively although they conceded that they could improve. They emphasised that they try to establish good rapport; trying to make patients feel comfortable, for example, by engaging them in small talk:

"I always try to make them to feel comfortable first of all, because the dentist is the place that nobody is comfortable." (F1)

Participants felt they were capable of communicating with patients in such a way as to exchange necessary information.

Ensuring patients' comprehension of treatment

Being understood and making sure that patients know their diagnosis and treatment options, was among the most important goals of these dentists. They highlighted the importance of speaking to patients clearly, without using jargon. They reported using different methods to help

explain concepts (e.g. using study models), as anxiety may impede a patient's comprehension. Establishing full understanding seems to be significant not only because of the requirement of obtaining informed consent, but also for the benefit of the patients' comprehension of treatment consequences and risks. Interviewees tried to verify patients' understanding by asking patients questions about the treatment even after agreeing on it, e.g.

"(...) you will ask them 'do you understand?', they will say 'yes' and then I will ask them 'ok, so what are we going to do?'" (F5)

Barriers to PCC

Time constraints

Time appeared to significantly affect dentists' interactions with the patients. All the dentists perceived that the time that is assigned for consultation or treatment (10-15 minutes) within the NHS is insufficient. They explained how it can be difficult to establish a good and trustful relationship with the patients, as this can be time-consuming and may require more than one session. When explicitly asked about applicability of a PCC model they admitted that it can be applied only to limited extent as there is simply not enough time:

"That's an idealistic relationship between a dentist and a patient, which is very rarely achievable in the limited times that we have on the NHS dental sessions." (M2)

Dental anxiety

Participants highlighted patient anxiety as a factor affecting communication. They discussed how some patients do not want to listen to their treatment descriptions, whereas other anxious patients actively want to know what to expect. Furthermore, anxiety may affect the patient's ability to comprehend dentist's explanations and describe their symptoms:

"Some patients can be very anxious and, you know, be very vocal but (...) they are not able to communicate the actual problem." (F7)

Some dentists felt dental fear impeded the timely establishment of a trustful relationship.

Patient demographics

Many participants believed that socio-economic (SE) or educational background affected patients' communication skills and cooperation with the dentist. Patients from lower educational and SE backgrounds were perceived as more indifferent to their oral health or interested only in solving a specific problem (e.g. aesthetics). The development of effective relationships with these patients was considered difficult, because they show less interest in dentists' explanations, or low comprehension of

them, and difficulties in describing their symptoms. Patients with a higher educational level or SE background on the other hand, were perceived to be better communicators, more responsible for their oral hygiene and more knowledgeable of consequences of negligence. Indeed, the dentists perceived they were more interested in their health overall:

"People with higher level of education are generally more interested in their general health." (F8).

Influence of stereotypes

The participants highlighted that dentists are frequently the target of social stereotypes. It is not uncommon for patients to think that the dentist is a money-orientated professional who does not care about patients' welfare but their only aim is profit:

'(...) sometimes people think dentists are just out to make money' (F7).

Additionally, the dentist as a figure-head for inflicting pain was also described as a common stereotype which could deter some patients from having the most appropriate dental treatment and impede communication.

Mutuality of communication

Most dentists emphasized the importance of politeness, kindness and respect from their patients. They try to be friendly so they appreciate the same response from their patients. Therefore, the reciprocity of the

feelings and attitudes appears to be vital. It seemed easier for them to communicate with patients when they show the willingness to cooperate, by precisely describing their symptoms and concerns and actively interacting with them. On the other hand, all participants pointed out aspects of patients' behaviours and attitudes that can significantly impede the establishment of effective communication.

"From the first moment they step in, an average of 70%, they say that they 'hate the dentist' instead of saying 'good morning'." (M2)

Additionally, a lack of patient respect to dentists as professionals and trust in their professional opinion was viewed negatively.

Salience of shared responsibility

The dentists highlighted the importance of patients' awareness of their responsibility for their oral health and its impact on patient-dentist interactions. They reported that patients need to understand dual responsibility in dentistry; dentists by taking care of patients' oral health and patients by brushing their teeth and regularly attending appointments. They felt frustrated when patients did not accept responsibility for their oral health or did not attend:

"I can do absolutely nothing if the patient sees me (...) one time for two or three years, or don't brush their teeth (...)" (F8)

Conversely, patients who try to be responsible for their oral health were perceived by dentists as more willing to cooperate with advice. Interactions with responsible patients were considered as a true partnership because the dentist appears to be treated as a specialist helping in maintaining a good oral health.

Patients' involvement in the decision-making process

Every dentist emphasized that their priority is to familiarize patients with the available treatment options. However, patients' awareness or willingness to be involved in the decision-making process varied. According to the dentists, many patients are aware of their autonomy, especially when they need to sign consent forms or choose between the treatment options. However, some patients prefer to be passive and attempt to pass the responsibility for decision making to the dentists, as an expert:

"(...) you are my dentist, you do what you think is best." (F5)

Nevertheless, many interviewees agreed that this attitude is not acceptable stating consent requirements encouraging dentists to make patients explicitly aware that they need to make the decision themselves:

"(...) 'they are your teeth and you have to decide, I can't make the decision for you' (F7).

The idea that patients' age, educational and confidence levels might influence patients' willingness to be autonomous in the decision-making process was, however acknowledged.

Discussion

Findings revealed that dentists rated themselves positively as communicators and they tried to adjust their communication style and service to patients' needs. In line with previous research (e.g., Scambler et al, 2014; Asimakopoulou et al, 2014) all dentists in the current study, although not explicitly aware of patient-centred models of consultation, claimed to actively employ them in everyday practice at least to some extent. They primarily appeared to treat each person as '*a whole*' considering their life circumstances and background. They reported that they attempt to divide power and responsibilities and take special care for patients' psychological comfort during the visit to gain their trust and make interaction work.

Although the dentists felt responsible for the flow of communication by attempting to facilitate the patient's participation in the consultation, it appeared that the patients themselves were partners in this process. The mutuality of the interaction process seen in medical encounters (Roter & Hall, 1992), is apparent in dental encounters too. In particular, the dentists' ability to communicate depends on the patients' capability to ask and answer questions, understand what the dentist says and express

their own opinion about the treatments (Street, 1991). This information exchange and reassurance of patients' comprehension was regarded by the dentists as central to the decision-making process. However, according to the dentists not all patients are aware of their autonomy in decision making or even willing to take active role – a finding that has been reported as a barrier to PCC in dental settings previously (Street, 1991; Freeman, 1999). Joseph-Williams et al (2017) state that clinicians often claim their patients do not want to be involved in decision-making, and that the shared decision-making process should respect this. However, this in itself should be informed and patients may also need support and preparation to take part in a different type of consultation. According to our participants, the age and educational background of patients influenced their participation, with younger and more educated patients being more likely to take an active role. Joseph-Williams and colleagues agree that research appears to show that older people are less likely to take an active role, and this may be related to previous experience and expectations of paternalistic consultations. While patients may vary in their desire for participation in health care decisions there's a critical difference between genuine desire for less participation and less participation due to expectations, experience or lack of necessary skills (Cegala, 2003). Future work should explore this from both a patient and dentist perspective.

Politeness and mutual respect encouraged dentists to establish a good rapport with their patients. This reciprocity of communication patterns was attributed by the dentists to the fact that, despite their professional position, they are, ultimately, social beings. The dentist-patient relationship is, therefore, strongly influenced by the typical 'laws' of social encounters, as previously reported in medicine (Stewart et al, 1995; Ong et al, 1995).

In terms of barriers, in line with other healthcare contexts (e.g., Moore et al, 2016) time was a barrier to patient-centred care. It should be noted that these dentists are working for the NHS; time may not be such an issue for those working privately. Negative stereotypes and dental anxiety were also found to impede a good dentist-patient relationship. Dentists found that developing a trusting relationship with anxious or prejudiced patients was hard work. For anxious patients, a fruitful patient centered communication strategy may be to use formal anxiety assessments (e.g., the Modified Dental Anxiety Scale; Humphris et al, 1995) to aid discussion about their fears and specific aspects of the patient experience (Hally et al, 2017). Compared to doctors, negative stereotypes seem to be associated more with the dental profession; indeed negative depictions are evident across various mediums including TV, films and the Internet (Henríquez-Tejo & Cartes-Velásquez, 2016). Attempting to revise preconceptions or negative stereotypes of dentists is perhaps a role for future research.

The focus of this study was on the dentist's own perceptions of communication. They report they use a patient-centered model in everyday practice. We did not set out to objectively corroborate this, and we do not have patient views to compare. However, these accounts are valuable, in that we see what dentists perceive as important, obstructive and facilitative in terms of consultations. They emphasise that in order to make the dentist-patient partnership work, patients need to be actively involved in the consultation - asking and answering questions, accepting responsibility in oral health maintenance and being actively involved in decision-making. There may be potential for getting patients actively involved within consultations, and for training in patient communication skills. However, dentists may also need training in helping patients from different backgrounds to get the most out of the consultation. Within this, there should be an appreciation that not all patients can, or have the means, to change their behaviours. For example, the choices that those in low socioeconomic groups have, may be constrained by the social context in which they live.

There are limitations to the study. Participants were self-selecting - they may have been confident about their own communication, or interested in communication skills. Furthermore, we sampled only from NHS dentists in England, so findings may not be applicable to other dental sectors (e.g. private) or countries. Our sample is also relatively young so their views might not be reflective of older dental practitioners. Further

research should investigate the themes identified in this small qualitative study in wider, more diverse groups of dental professionals.

In conclusion, the study has highlighted the importance of patients getting actively involved within consultations, and patient communication skills training. However, dentists may need training in helping patients from different backgrounds to be actively involved in the consultation. The challenge of implementing these conclusions in practice remains.

References

- Asimakopoulou, K, Gupta A, Scambler S. (2014). Patient-centred care: barriers and opportunities in the dental surgery. *Community Dent Oral Epidemiol* 42(6):603-10.
- Berson JM, Hallberg LR-M, Elfström LM, Hakeberg M. (2011). Making dental care possible- a mutual affair. A grounded theory related to adult patients with dental fear and regular dental treatment. *Eur J Oral Sci* 119: 372-80.
- Braun V, Clarke V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3:77-101.
- Brennan DS, Spencer AJ. (2006). Dentist Preferences for Patients: Dimensions and Associations With Provider, Practice, and Service Characteristics. *Int J Behav Med.* 13:69-78.
- Cegala DJ. (2003). Patient communication skills training: a review with implications for cancer patients. *Patient Educ Couns* 50:91-94.
- Freeman R. 9 (1999). Communicating effectively: some practical suggestions. *Br Dent J.* 187:240-244.
- Hall JA, Roter DL, Katz NR. (1988). Meta-analysis of correlates of provider behaviour in medical encounters. *Med Care* 26:657-675.
- Hally J, Freeman R, Yuan S, Humphris G. (2017). The importance of acknowledgement of emotions in routine patient psychological assessment: The example of the dental setting. *Patient Educ Couns.* 48:201-206.
- Henríquez-Tejo R & Cartes-Velásquez,RA (2016). Patients' perceptions about dentists: A literature review. *Odontoestomatologia*, XVIII (27), 15-22.

Joseph-Williams N, Lloyd A, Edwards A, Stobart L, Tomson D, Macphail S, Dodd C, Brain K, Elwyn G, Thomson R (2017). Implementing shared decision making in the NHS: lessons from the MAGIC programme. *BMJ* 357:j1744 doi: 10.1136/bmj.j1744

Kaplan SH, Greenfield S, Ware JE Jr. (1989). Assessing the effect of physician-patient interactions on the outcomes of chronic disease. *Med Care* 27:110-127.

Kulich KR, Berggren U, Hallberg LR-M. (2003). A Qualitative Analysis of Patient-Centered Dentistry in Consultations with Dental Phobic Patients. *J Health Commun* 8:171-187.

Mead N, Bower P. (2002). Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Educ Couns.* 48(1):51-61.

Mead N, Bower P. (2000). Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci & Med* 51(7):1087-1110.

Milgrom P, Cullen T, Whitney C, Fiset L, Conrad D, Getz T. (1996). Frustrating Patient Visits. *J Public Health Dent* 56:6-11.

Moore L, Britten N, Lydahl D, Naldermirici O, Elam M, Wolf A (2016). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scand J Caring Sci*, 31; 662-73.

Ong LML, De Haes JCJM, Hoos AM, Lammes LB. (1995). Doctor-patient communication: A review of literature. *Soc Sci Med.* 40:903-918.

Patton MQ. (1990). *Qualitative evaluation and research methods*, 2nd edition. Sage, 1990

Roter DL, Hall JA. (1992). *Doctors Talking with Patients. Patients Talking with Doctors.* Westport (CT): Auburn 1992.

Rouse RA, Hamilton HA. (1991). Dentists evaluate their patients: An empirical investigation of preferences. *J Behav Med.* 14:637-648.

Scambler S, Gupta A, Asimakopoulou K. (2014). Patient centred care what is it and how is it practice in the dental surgery? *Health Expect.* 2014; 18(6):2549-58.

Scambler, S. and K. Asimakopoulou. (2014). A model of patient-centred care - turning good care into patient-centred care. *Br Dent J.* 2 217(5): 225-8.

Sondell K, Söderfeldt B, Palmqvist S. (2003). Underlying dimensions of verbal communication between dentists and patients in prosthetic dentistry. *Patient Educ Couns.* 50:157-165.

Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. (2003). *Patient-centered medicine: Transforming The Clinical Method.* Oxford: Radcliff Medical Press.

Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. (1995). *Patient-centered medicine: Transforming the clinical method.* Thousands Oaks (CA): Sage.

Street RL Jr. (2003). *Communication in medical encounters: An ecological perspective.* In: Thompson T, Dorsey A, Miller K, Parrott R, ed. *The handbook of health communication.* Mahwah, NJ: Erlbaum. 63-89

Street RL Jr. (2002). Gender differences in health care provider-patient communication: are they due to style, stereotypes, or accommodation? *Patient Educ Couns.* 48:201-206.

Street RL Jr.(1991). Information-giving in medical consultations: The influence of patient's communicative style and personal characteristics. *Soc Sci Med.* 32:541-548.

Street RL. (1992). Communicative style and adaptations in physician-parent consultations. *Soc Sci Med.* 34:1155-1163.

Williams SJ, Calnan M. (1991). Convergence and divergence: assessing criteria for consumer satisfaction across general practice, dental and hospital care. *Soc Sci Med.*33:707-16.

Woelber JP, Deimling D, Langenbach D, Ratka-Küger P. (2012). The importance of teaching communication in dental education. A survey amongst dentists, students and patients. *Eur J Dental Ed.* 16:e200-e204.