Philip RH Newsome

Colman McGrath

# Patient-Centred Measures in Dental Practice: 1. An Overview

**Abstract:** This paper explores the way that patient participation has increased in dentistry in recent years and introduces the two concepts of 'quality of life' and 'patient satisfaction' and examines their relevance to everyday clinical dental practice.

**Clinical Relevance:** By better understanding the concepts of 'quality of life' and 'patient satisfaction' dentists can tailor clinical solutions that take into account the way patients participate in decisions about their own dental care.

**Dent Update 2006; 33: 596-600**

## The growth of consumerism in dental practice

Dental practice has undergone enormous changes over the past 20 years. The most obvious of these have, perhaps, been the various, highly significant, clinical developments. Less obvious, but none the less meaningful, changes have come in the nature of the relationship between dentists and their patients. For many years, dentistry was a rather paternalistic profession based on the assumption that 'dentist knows best'. Through the 80s and 90s the push for a more patient-centred approach gathered strength and with it a more consumer-driven style of healthcare delivery in which consumer choice would play an increasing role in what services were to be provided and how. The purpose of this paper is first, to introduce the concept of patient-centred care, secondly, to define 'patient satisfaction' and 'quality of life' and finally, to explore the relevance of these differing concepts to modern dental practice.

**Philip RH Newsome**, BChD, MBA, PhD, FDS RCS(Ed), MRD RCS(Ed), Associate Professor, and **Colman McGrath**, BA BDentSc, MSc, PhD, DDPH RCS, FDS RCS, FFD RCSI, Associate Professor, Faculty of Dentistry, University of Hong Kong, 34 Hospital Road, Hong Kong SAR, China.

## Patient-centred care

In general terms, patient-centred healthcare can be defined as care that seeks to minimize the current and future experience of illness and to minimize the negative experience of healthcare provision. In 1995, Sir David Mason[1] identified the 'consumer revolution' as being a major influence on the future of dental practice in the UK:

*More people want more say about their health and health services, the best care for themselves and their families and choice in that care. For the NHS the result has been a profound shift in emphasis from service providers to patients, the full effects of which have yet to be realised.*

On the one hand, Lupton[2] took the view that patients 'consume' dentistry just as they would any other product or service:

*Patients are consumers no less than supermarket shoppers or users of other services. The same principles apply: Know what you want, shop around, and if the service is unsatisfactory, take your business elsewhere or seek redress.*

On the other, Williams and Grant[3] have observed that consumerism in healthcare is different and imposes added responsibilities which the individual user might find difficult or impossible to fulfil and quote – 'in other words, patients may be encouraged to act as consumers but may, however, feel reluctant/uncomfortable doing so'. There is, nevertheless, an overall push from consumer groups demanding a greater involvement in the care received.[4]

However, a rise in consumerism is not the only reason why dentists have become increasingly interested in incorporating aspects of 'quality of life' and 'patient satisfaction' into their practices. Put simply, it makes good business sense. Dentistry in the UK has become increasingly competitive over the past decade and corporate dental groups are investing in high quality, modern practice facilities in order to attract practitioners, as well as provide the highest standard of care and choice for patients. It has been suggested that many such bodies corporate have instituted more rigorous patient satisfaction measures in their operations as compared to non-corporate practices.[5] Patient feedback from the Oasis corporate dental group, for example, has shown that patient satisfaction is high where practices have been refurbished and modernized, findings echoed by James Hull and Associates.[6] As

a result of these, and other, driving forces (for example, deregulation allowing dentists to market their services more effectively to the wider population, resulting in a greater proportion of elective procedures and greater amounts of information being available in printed and electronic media), there has been a broad move within both the National Health Service and private practice to embrace the notion of patient participation in the delivery of dental care. A report published in 2003 by the Office of Fair Trading, The Private Dentistry Market in the UK[7] acknowledged this and recommended that consumers be provided with:

*…better information if they are to be in a position to make properly informed choices about which dentists and treatments will best meet their needs.*

Such information would ideally help consumer/patients address the five issues described by Potter[8] namely, access, choice, information, redress and representation:

*People must first of all have access to the benefits offered by a product or service. Their choice of products and services must be as wide as possible to establish some measure of consumer sovereignty, and they need as much information as possible, both to enable them to make sensible choices, and to make the fullest possible use of whatever it is they are seeking. They will need some means of communicating their grievances when things go wrong, and receiving adequate redress. Finally they need some means of making sure that their interests are adequately represented to those who take decisions affecting their welfare.*

This is then the background against which patients must evaluate the care they receive and relevant to this evaluation process are the concepts of 'satisfaction' and 'quality of life'.

## Defining patient satisfaction

Patient satisfaction (or perhaps more correctly, user satisfaction) can be defined in a number of different ways. 'Satisfaction' is derived from the Latin *satis* (enough) and *facere* (to do or make) a related word being 'satiation' (loosely meaning 'enough' or 'enough to excess'). Some of the most thorough attempts to understand satisfaction can be found in the marketing literature – Rust and Oliver[9] concluded that satisfaction implies a feeling of fulfilment and therefore may be seen as a 'fulfilment response'. It has been argued, however, that the satisfaction response is more than mere fulfilment and that fulfilment takes various forms:[10]

- Satisfaction as contentment – this assumes that the product or service performs satisfactorily in an ongoing, passive, sense;
- Satisfaction as surprise – high arousal satisfaction which can be positive, for example, delight, or negative, for example, shock;
- Satisfaction as pleasure – results when positive reinforcement occurs, such as when a product or service adds utility or pleasure to a non-negative resting state;
- Satisfaction as relief – results from the removal of an aversive state.

In attempting to provide definitions, the literature sees satisfaction either as an outcome or as a process. Initially, satisfaction was viewed as an outcome resulting from the consumption experience, for example:[11] *the cognitive state of being adequately or inadequately rewarded.*

In time, however, satisfaction began to be defined as a process incorporating some element of evaluation, for example:[12] *an evaluation that the consumption experience was at least as good as it was supposed to be.*

This latter approach, which emphasizes the perceptual, evaluative, and psychological processes that combine to generate satisfaction, has come to predominate in the literature.

## Defining 'quality of life'

Quality of life (QOL) is a somewhat abstract phenomenon for which a precise and consensual definition has yet to be agreed. The general notion of 'quality of life' relates to happiness or 'goodness' of life and there is general agreement that health is important, if not central, to life quality. The World Health Organization has defined 'quality of life' as a broad-ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, and his/her relationship to the salient features of the environment.[13] Oral health is an important component of general health and the term 'oral health related quality of life' has been coined to describe the physical, social and psychological aspects of oral health status.[14] Understanding the impact of oral health on life quality is important on many fronts:

- In drawing attention to the importance of oral health to a patient's life;
- Understanding oral health need from a patient's perspective; and
- In the delivery of oral healthcare that addresses a patient's needs and concerns.

Moreover, in the current climate of patient-centred healthcare, an understanding of the outcomes of oral healthcare, from a patient's perspective and perceived changes to life quality, is likely to be important in prioritizing oral healthcare and informing evidence-based practice.

## Relevance to dental practice

The foregoing discussion is only of any real use to the practising dentist if it can be fed into everyday activities. It therefore seems to make sense that, given this sea-change in dentist-patient relationships, we as a profession attempt to understand how greater patient participation affects us and how we can manage our practices accordingly. By doing so we will more likely provide services that are appreciated and valued by our patients; ones which are most likely to secure long-term benefits.

It is possible that, as the level of a patient's participation increases, so does the evaluation of:

- the service provider, the nature of service, how that service is delivered, how it is paid for; and
- the degree to which he or she has benefited from the care received.

In other words, patients firstly make judgements on what we do, how we do it and the price they pay to receive it. Such evaluations, that is on the manner in which the service was delivered, may be relatively transient but may, for many people, endure for a lifetime. Shortly afterwards, they will begin to evaluate the perceived benefits of receiving that service. This latter evaluation will most likely focus on how well the treatment relieved discomfort, restored function and improved appearance.

Evaluation can thus be divided into two distinct parts. First, 'satisfaction' with the process of service delivery and, secondly, an appraisal of how 'quality of life' has been improved as a result of receiving the treatment. We stress that these two concepts, while closely related, are nevertheless distinct. For instance, it is possible for a patient to be satisfied with the dentist, the way the treatment was provided and the cost of that treatment only for the end result to be little or no improvement in ultimate quality of life. One possible explanation for this phenomenon is the concept of attribution by which a patient blames him/herself for any failings in treatment.[15] For example, a patient might neglect his or her teeth for several years before finally visiting a dentist. The dentist tries to salvage the dentition but ultimately fails and the patient is left wholly or partially edentulous. The patient might reasonably conclude that 'The dentist did his best but it was really my fault in the first place that I am now in this position'. In other words, the patient assigns blame to him/herself rather than to the dentist.

## Providing better information to patients

A recurring theme is the need to provide consumers with better information. A common problem in dentistry is communicating with patients. Medical jargon is often used to describe oral health problems and how to treat them. Unfortunately, the usual result is that the patient understands neither the problem nor the purpose of any proposed treatment. 'Satisfaction' and 'quality of life' indicators may provide the tools to describe the problem and the benefits of treatment in lay terminology, thus facilitating communication and understanding. This could also facilitate patient participation, allowing patients to express their oral health needs, and perceived needs.

## Focusing on benefits

By understanding those factors that patients themselves consider important, it is possible to market our services to make them appealing to the public at large. Patients most often wish to improve aspects of their current oral health rather than demand a specific treatment. It follows that dentists would therefore be best advised to focus on benefits and outcomes of various treatment alternatives rather than providing in-depth descriptions of the technical intricacies of the various procedures. 'Quality of life' indicators highlight the benefits of treatment – such as how implant therapy may improve aspects of one's quality of life (eating and its enjoyment to name just one). They may also be used in marketing preventive dental care by illustrating how prevention can reduce the negative impacts of oral disease on the quality of life (pain and discomfort).

## Understanding how patients evaluate dental care

Similarly, parameters of satisfaction can be incorporated into any information communicated to patients, so informing them of the ways a practice will endeavour to care for them…as people… before, during and after the delivery of dental care. Such parameters, as will be seen in part three of this series, centre largely on a range of soft, non-technical aspects of dental practice such as comfort, cost and convenience – patients simply do not feel they have the requisite technical understanding to evaluate much of the treatment they receive, the following quote from a patient cited in one qualitative study being typical:[16] *A lot of dentists use too many technical terms that the average person in the street doesn't understand or know anything about. I think they should be taught to use more basic language.*

Because it is so difficult for patients to make any form of evaluation of dental care before it has been delivered, dentists are increasingly realizing the importance of traditional word of mouth messages as perhaps the most important method of conveying information to, as yet, unseen patients. Accordingly, whenever existing patients are encouraged to spread positive word of mouth messages about a particular dentist or treatment, it has to be realized that such word of mouth information will be phrased in terms relating to satisfaction with the care received and the subsequent quality of life benefits. It is highly unlikely that patients will leave a dentist enthusing about the new apex locator! Instead, the conversation will much more likely revolve around the absence of pain and swelling, the kindness of the dentist and his/her nurse, the way the bill was explained and so on. As interesting as new technology might be to the dentist, it usually means little to the average patient who is more bothered about the softer aspects of the process and the (hopefully) positive benefits accrued in terms of function, appearance, absence of discomfort, etc.

## Summary

It seems likely that patients will continue to have an increasingly large say in the type of dental care they receive in the future, however frustrating this might be for those dentists who simply want to get on and do the work without spending too much time talking about it. The next two articles in this series will explore how knowledge and understanding of patient satisfaction and quality of life issues can be used to the advantage of everyone – care providers and recipients alike.

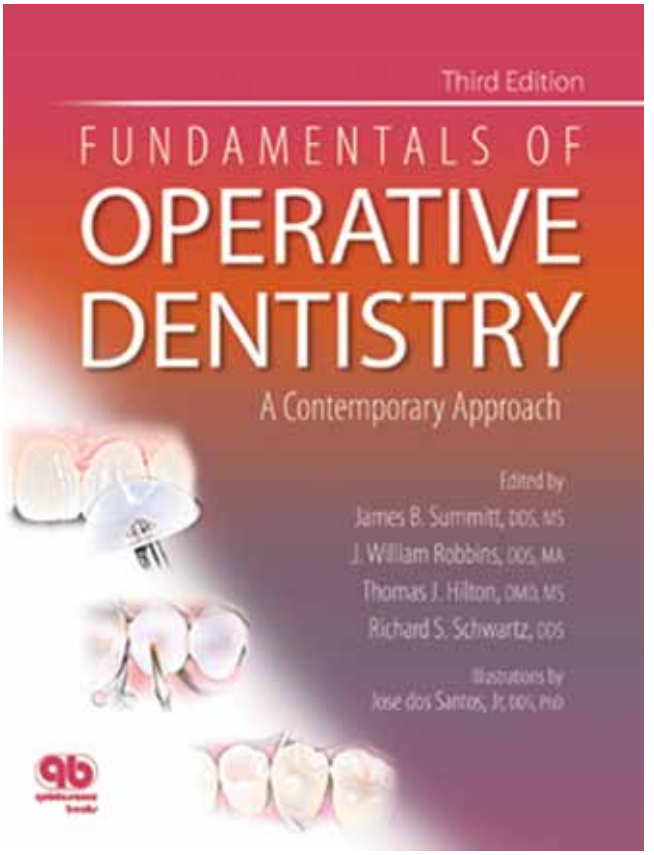
## References


1. Mason D. General dental practice – challenges and opportunities: a personal view. *Br Dent J* 1995; **179**: 350–354.
2. Lupton D, Donaldson C, Lloyd P. Caveat emptor or blissful ignorance? Patients and the consumerist ethos. *Social Science and Medicine* 1991; **33**: 559–568.
3. Williams B, Grant G. Defining 'people-centredness': making the implicit explicit. *Health and Social Care in the Community* 1998; **6**: 84–94.
4. Consumer Association. *Which Magazine*. October, 2001.
5. Newsome P. Dental bodies corporate and their approach to customer care. *Br Dent J* 2002; **192**: 572–575.
6. *Evidence to the Doctors' and Dentists' Review Body for the 33rd Report*. London: British Dental Association, 2003; p.20.
7. *The Private Dentistry Market in the UK*. London: Office of Fair Trading, 2003.
8. Potter J. Consumerism and the public sector: how well does the coat fit? *Public Administration* 1988; **66**: 149–164.
9. Rust R, Oliver R. Service quality: insights

and managerial implications from the frontier. In: *Service Quality: New Directions in Theory and Practice*. R Rust, R Oliver, eds. Thousand Oaks, CA: Sage, 1994.
10. Oliver R. Processing of the satisfaction response in consumption: a suggested framework and research propositions. *Journal of Consumer Satisfaction, Dissatisfaction and Complaining Behavior* 1989; **2**: 1–16.
11. Howard J, Sheth J. *The Theory of Buyer Behavior*. New York: Wiley, 1969.
12. Hunt H. Consumer satisfaction/ dissatisfaction – overview and future research direction. In: *Conceptualization and Measurement of Consumer Satisfaction and Dissatisfaction*. Hunt D, ed. Cambridge MA: Marketing Science Institute, 1977.
13. WHOQOL Group. *Measuring Quality of Life: The Development of the World Health Organisation Quality of Life Instrument (WHOQOL)*. Geneva: World Health Organisation, 1993.
14. Cohen L. The emerging field of oral health-related quality of life outcomes research. In: *Measuring Oral Health and Quality of Life*. Slade GD, ed. Chapel Hill: University of North Carolina, Dental Ecology, 1997.
15. Williams B, Healy D. The meaning of patient satisfaction: an explanation of high reported levels. *Soc Sci Med* 1998; **47**: 1351–1360.
16. Newsome P, Wright G. Qualitative techniques to investigate how patients evaluate dentists: a pilot study. *Community Dent and Oral Epidemiol* 2000; **28**: 257–266.

## BookReview

**Fundamentals of Operative Dentistry – A Contemporary Approach** 3rd edn. Edited by James B Summitt, J William Robbins, Thomas J Hilton, Richard S Schwartz. Chicago: Quintessence Publishing Co Inc, 2006. ISBN 0-86715-452-7.




Operative Dentistry continues to undergo rapid change. An improving understanding of dental caries, increasingly effective prevention and the ever-broadening range of restorative materials and techniques make writing an operative dentistry textbook a challenge. There is a risk that a book is well out-of-date by the time that it is published, or else it is thought to be too traditional or so modern that it lacks practical application. This new edition of *Fundamentals of Operative Dentistry* steers a measured course between these obstacles and, in the opinion of the reviewer, is the best text on Operative Dentistry currently available.

It is a multi-authored text but nevertheless reads in a coherent manner. There are 20 chapters with an impressive list of contributing authors. The book is attractive and easy to read, both in terms of style and presentation.

It is perhaps a mistake to comment on specifics in the book as adverse statements may carry weight that is out of proportion to their importance. This is a fundamentally good book and contains a wealth of excellent practical information supported by the available evidence.

The opening chapter on 'Biologic Considerations' contains some clearly explained dental anatomy and histology but relates these to clinical practice. The text then follows a logical progression through diagnosis and treatment planning, aesthetics and the management of dental caries. The chapter on the management of the dental pulp is up-to-date and is one of the first to provide an in-depth analysis of dentine adhesives and traditional lining and base materials. The use of rubber dam is described excellently by authors who clearly use it routinely: it is full of helpful practical hints. Adhesion is well covered, whilst the chapter on direct posterior composite restorations is recommended and that on natural tooth bleaching by Haywood and Berry is clear and informative.

Unfortunately, there were disappointments with the text. The chapter describing complex amalgam restorations contains descriptions of the use of dentine pins which are historical. The final restorations are excellent but the premise on which these are based is flawed. In a subsequent chapter on root caries, the use of four pins to retain a silver amalgam restoration in a buccal Class V cavity is described: an approach that has little to commend it. On the other hand, this chapter shows beautiful pictures of isolation of the operating field. After that, the book deteriorates, with the last five chapters becoming increasingly ordinary. These deal with veneers, crowns and posts. Better accounts are available elsewhere.

However, this is an excellent, well-illustrated book and a pleasure to read. It provides a wealth of well-referenced knowledge, embracing the prevention of dental disease and shows an excellence in operative dentistry that should inform, encourage and challenge. It is suitable for all dentists and therapists.

**Richard Ibbetson**
**Edinburgh Dental Institute**