IN BRIEF

- A qualitative study of the meaning of oral health for people with visibly damaged teeth who did and did not go to the dentist.
- The relevance of oral health varied between people and changed over time.
- People constructed their own 'margins of relevance' of oral health, which influenced dental attendance.
- Dentists can explore and challenge the margins of relevance to open new horizons for their patients.

The perceived relevance of oral health

The relevance of oral health for attenders and non-attenders: a qualitative study

J. Gregory,[1] B. Gibson[2] and P. G. Robinson[3]

ABSTRACT

Background
Low expectations of health mean that oral health becomes a low priority for some people, an appreciation of which would help dentists when a non-attender does come to the surgery.

Objective
To provide an insight into why oral health is not important to some people and how this attitude might hinder access to dental care.

Method
In this qualitative study, purposive sampling was used to recruit two groups of participants with sociably visible missing, decayed or broken teeth but apparently differing responses to that status. The data analysis used social systems theory as operationalised by grounded theory techniques.

Results
The core category that emerged from the data was that people constructed their own 'margins of the relevance' of oral health. For some people oral health was highly relevant whilst for others it was not very relevant. The degree of relevance of oral health was organised along seven dimensions: the perceived 'normal' state of oral health, the perceived causes of oral health and disease, the degree of trust held in dentistry, perceptions of oral 'health' as a commodity, perceptions of the accessibility of oral health care, perceptions of 'natural' oral health and judgements of character.

Conclusions
If certain aspects of oral health are not relevant, little that is said about those aspects will be meaningful to people. The key is to either emphasize or gently challenge those ideas and beliefs that allow or hinder the margins of relevance.

EDITOR'S SUMMARY

With oral disease levels falling not only is more time potentially released for us to spend with our patients but also for researchers to delve into areas that might previously have had to wait in line behind other projects. This qualitative study is a type we may well see more of in the future since, as its name suggests, it probes into attitudes and behaviours, in this instance in an attempt to help us to better understand why some people attend regularly and others do not.

What comes across in reading the paper is that with time and understanding people's attitudes can be influenced and changed. We all have stories to tell of patients who have surprised us by acting or behaving in ways that we had not anticipated in our initial assessment, and sometimes with very beneficial results for both patient and practitioner. Here, consideration of images of other people's teeth and mouths are shown to be aspirational for some of those with poorer oral status in a way that might not have been expected on first judgement. Studying these responses may help us to improve access to care for more potential and previously reluctant patients.

The paper contains a good deal of what might politely be termed 'jargon', for example 'margins of relevance'. Even if these are terms and concepts with which we are not as familiar as quantitative scientific measures, it is worth the tenacity of climbing through the 'qualitative' language and discovering that there is a lot of potential value in taking our immediate focus away from the minutiae of the mouth to look at the wider picture of the patient's perception.

The full paper can be accessed from the *BDJ* website (www.bdj.co.uk), under 'Research' in the table of contents for Volume 202 issue 7.

Stephen Hancocks OBE, Editor-in-Chief

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FULL PAPER DETAILS

[1]PhD Student, Unit of Oral Health Services Research and Dental Public Health, Room 229, Guy's, King's and St Thomas' Dental Institute, King's College London, Caldecot Road, Denmark Hill, London, SE5 9RW; [2]Senior Lecturer, [3*]Professor of Dental Public Health, Department of Oral Health and Development, School of Clinical Dentistry, University of Sheffield, Claremont Crescent, Sheffield, S10 2TA
*Correspondence to: Professor Peter G. Robinson
Tel: +44 (0)114 271 7892
Email: peter.g.robinson@sheffield.ac.uk

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AUTHOR QUESTIONS AND ANSWERS

Why did you undertake this research?

We were interested in the impact of the mouth on the everyday lives of people who had visibly decayed, broken or missing teeth.

There has been debate about whether it is possible to assess the need for dental treatment by using questionnaires to measure these kinds of impacts (called 'oral health-related quality of life' [OHQol]). We were concerned that some people may have bad oral health but not realise that it affected their everyday life. People with visibly bad teeth were chosen for this reason. By showing that subjective assessments of quality of life vary, the results mean that OHQoL should be used in needs assessment and evaluation of treatment with care.

This paper is an interesting by-product of the research as it also provided new insights into the ways people who do not go to the dentist view oral health and the dental profession. The paper provides useful tips on how to care for such people when they do become patients.

What would you like to do next in this area to follow on from this work?

A number of ideas spring from this work. First of all, we believe that OHQoL assessments could be supplemented by measuring the relevance of oral health to the individual. We saw that the relevance of oral health changed for some people over even a very short time, depending on their circumstances.

Secondly, the attitudes of people who do not go to the dentist are rarely studied in dental research. This research could be important as these are the very people who may have most to benefit from dentistry.

Finally, the findings support the view that more work could be undertaken on the communication skills of dentists. Some of which could ascertain what skills they need, and some could focus on the educational aspects of enhancing those skills during education and continuing professional development.

COMMENT

This qualitative study explores how people understand oral health, and concludes that individuals' ideas about oral health can be summarised across seven dimensions, which are more or less relevant for each individual according to their circumstances. The authors discuss the implications of these findings primarily in terms of communication between dentist and patient. Patients tend to interpret messages from healthcare professionals in terms of their own framework of understanding, and messages which are coherent with patients' existing understanding are more likely to induce behaviour change.[1] This paper provides a guide to the possible frameworks which patients may be using in terms of their oral health, together with a guide to identifying the relevant dimensions. It is argued that using these techniques will enhance patient compliance, most notably with attendance at the clinic. However the extent to which this is true remains to be determined.

These findings, however, also have implications beyond the communication between dentist and patient. The notion that an individual's construction of their oral health will vary across time and circumstance is relevant to our understanding of the outcome of dental care. A person who commences treatment with a limited construction of their health needs, such as getting out of pain, may, once their initial need is met, shift their expectations. The patient's perceived need may actually increase following treatment, and they may report greater impact on, for example, quality of life. Thus, paradoxically, the initial treatment may have made the patients' perceived oral health worse. The findings have implications for understanding the plasticity of health.[2]

It is also likely that perceived relevance of the dimensions of oral health is influenced by social forces, including oral and facial images in media such as advertisements and films.[3] The model described here provides a possible mechanism for understanding how media pressures influence uptake of dental care, in particular aesthetic treatment.

J. T. Newton, King's College London

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