First impressions

Meeting and greeting in the clinical setting – are we doing what patients want?

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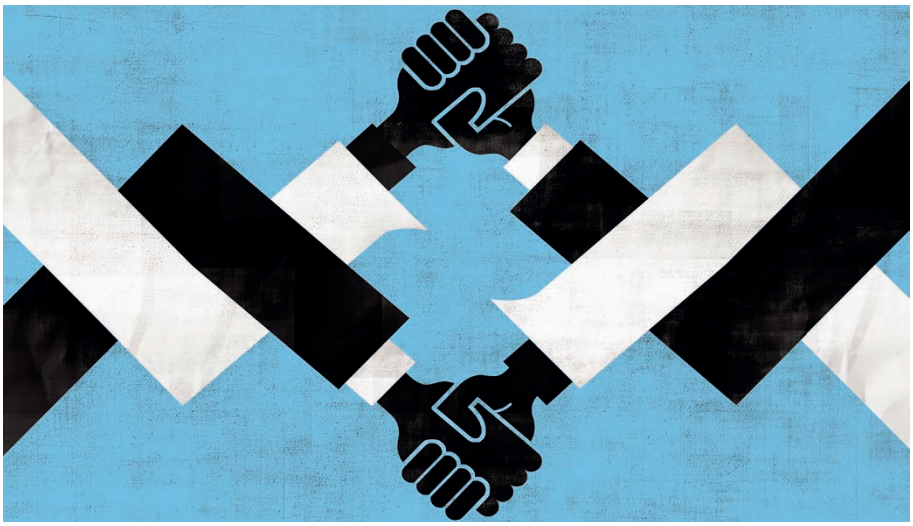

First impressions mean a lot. Those first few seconds can make a huge difference in how people perceive each other and this can ultimately shape future relationships. So how would you introduce yourself in a professional setting? Would you shake hands? Hug? Fistbump? And how do you prefer to be addressed? Do you prefer the formality of titles or does a first name basis put you at ease? There is very little research on patient preferences regarding first appointments with dentists, and so to determine what patients want author Ayisha Davies-House and her colleagues have carried out a survey of 450 patients attending Liverpool University Dental Hospital.

The authors point out that the generations have collective attitudes due to the society in which they grew up and so have arranged the patients' answers into generational cohorts. It is widely accepted that younger generations, for example Generation X and in particular millennials, are more informal, so it was unsurprising to see that more older patients preferred to shake hands with their clinician than younger patients. However, across the board the majority of respondents preferred to be addressed by their first name. This may be because by removing formalities patients feel more at ease, thus reducing anxiety. The majority were also indifferent to how the clinician introduced themselves and many others preferred the clinician to introduce themselves by their first name. This supports the argument that a more informal greeting approach tends to put the patient at ease. The authors suggest that a more formal introduction (such as 'Doctor') could lead to a paternalistic relationship causing the patient to view the relationship as unequal. This may lead to problems if the clinician requires the patient to make decisions.

The majority of respondents were also unaware of what the titles and grades of staff meant but they believed it would be helpful to know. Differentiation between members of staff can be helped by wearing uniforms, and previous studies suggest that this also ensures the patient is confident in the clinician's skills and more relaxed.

The authors conclude that clinicians should consider first name introductions and handshakes with older patients, but they must also consider each patient's body language and demeanour before choosing their approach.

By Jonathan Coe

Author Q&A

with Ayisha Davies-House
Liverpool University Dental Hospital

What made you study how patients wish to be greeted?

The incentive to undertake this research project all stems from a disagreement! My consultant and I differed in our approach to greeting patients at initial encounters, and following discussion with our colleagues, we soon realised that there was a great deal of variation in how patients were being greeted within the hospital. After undertaking a literature review to settle the argument, we concluded that there was very little research available to reach a consensus, and so we decided to undertake the research ourselves to establish the facts.

What were the clinicians' responses to the outcome of the study?

The findings were presented at the hospital's annual study day, and have sparked a fair amount of discussion. The Generational Theory is a fascinating concept, and although not all staff have agreed with the theory, it has resulted in an opportunity to learn, not only from the study's findings, but also from each other as healthcare professionals. Ultimately, we undertook the project not only to establish patient preferences but also to make readers question how they greet their patients on a daily basis, and to consider if they could adapt their approach to benefit dentist-patient relationships and ultimately improve patient care.

What would you like to do next?

The next step will be to present these findings to the Trust with the hope of implementing some changes, such as installing signs in waiting areas detailing different training grades and introducing colour coded uniforms to enable these training grades to be identified. As we are an undergraduate teaching hospital, our students will also be informed of the results to ensure that their approach to patient greetings complies with our recommendations and continues during their future careers. Ultimately, I hope is that clinicians, in both primary and secondary care, will have a better understanding of the importance of making a good first impression. ■

Putting your money where your mouth is

Natural tooth preservation versus extraction and implant placement: patient preferences and analysis of the willingness to pay
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Many readers will be familiar with the expression 'putting your money where your mouth is'. In essence it is a blunt entreaty to back up with real actions that which one says, an urge to commit to a decision not merely to discuss it. This study put the sentiment literally to the test by asking patients how much they would be prepared to pay for a procedure for their choice of treatment. Although this is in tune with the changing healthcare landscape in which the patient's opinion about their treatment is now central to valid consent and in which process they are regarded as a key to its success, the interposition of cost adds a further complicating factor, and arguably a moral one.

In this study patients were presented with a fictitious scenario in which they had to decide whether a 'hopeless' tooth should be saved through endodontic therapy and crown placement, or extracted and replaced by an implant and a crown. Both treatment options were priced at an initial starting price of €2,000, the market rate in Italy, where the study was undertaken.

About three quarters of participants opted for the more conservative approach of the root canal treatment, many of whom had previously experienced restorative treatment of one type or another. Of those who had previously undergone a surgical procedure a significant number opted for the non-surgical option. The matter of cost showed a greater variation with 42% unwilling to pay the amount proposed and 46% prepared to pay more. Participants were asked to decide at what level they would pay incrementally by €100 steps up or down resulting in the mean value being €1,926; not so far from the proposed starting price.

Interestingly, none of the patients decided to request 'no treatment' which may be either a measure of their desire for good oral health and/or their cultural acceptance that treatment comes with a cost. It would be interesting to run a similar study in say, the UK, where patients are accustomed to the National Health Service. Here treatment is ostensibly 'free at the point of delivery' although in reality the majority of adults pay some direct costs to the government through collection by the dentist.

Author Q&A

Silvio Taschieri
Università degli Studi di Milano

Why did you choose to carry out this research?

Patients are the core of the dentist's activity and that's the reason why clinicians should involve the patient in the decision making process. This research is a part of a project regarding patient's preferences. After being informed about pros and cons of each hypothetical therapeutic option, patients were requested to express their preferences regarding the treatment planning and their willingness to pay for the chosen therapy. As it is known that education, family attitudes towards dentistry and previous experience can affect the decision of the patient, these parameters were also taken into account.

Anything surprise you in the results?

We were not surprised by the fact that patients preferred endodontic therapy, because trying to save one's teeth should be the rule in dentistry. What was surprising is the fact that most of patients were willing to pay additional money to receivvthe treatment they preferred, regardless of proposed therapy, previous experience, age or personal income. The literature reports that financial issues have negative effects on dental visiting and oral health, especially in patients with a low budget, so we expected a greater difference among these groups.

Did you get an idea of the reasons behind the patients' preference?

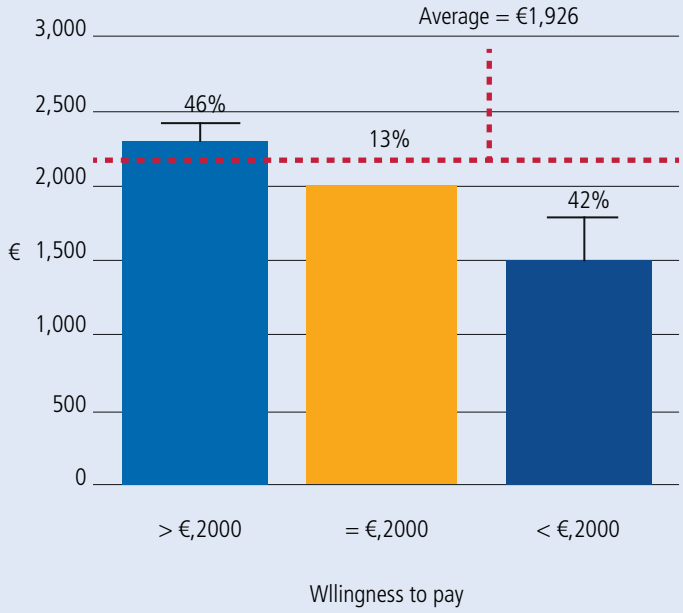
he results of our paper are in accordance with other studies indicating that endodontic and restorative treatment is preferred over extraction and implant placement, but clinical and cost data may indicate that there could be an increased choice toward implants in the future. High-level dentistry is leading more towards keeping teeth by means of endodontics and restorative dentistry, and involving the patient in the decision process. In some socio-economic situations, implants are considered as a long-lasting solution, cheaper than the conservative approach. This could influence the patient's decision. It would be interesting to repeat the study in a hospital or a public structure, to see if the different environment has an influence on the decision of the patient.

How much are you willing to pay to pay for treatment?

Treatment options:
1) root canal treatment *versus*
2) extraction and implant placement

No difference in willingness to pay

Mean willingness to pay value of patients regardless of the new treatment solution



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The 'value' of dental treatment and the 'value' of oral health are very difficult to separate and define. Adding a monetary element provides one potential measure of those values to a patient and may be helpful at least to the extent of making them gauge the relativities of health care to other areas of spending.

By Stephen Hancocks

Expert view

Farhad B. Naini
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This investigation, from a team at the University of Milan, is important as it attempts to answer a potentially perplexing question facing patients and their dentists on a daily basis, ie for a tooth with very poor prognosis and a choice between the two options of root canal treatment + crown versus extraction + implant placement and crown, what is the patient's preference? A secondary question is the relevance of cost to the patient's decision.

For both the patient and the clinician, when faced with such a question, it is ultimately the proposed *outcome* of the treatment that should be the determining factor, in terms of function, aesthetics and potential longevity.[1] These considerations depend on *which* tooth is involved, though the authors have not stated which tooth was specified in their investigation. For example, if the discussion is with respect to a maxillary central incisor, dentogingival aesthetics will take centre stage in the decision making process. Will it be difficult to obtain an acceptable gingival and papillary contour around an implant (an area of continued investigation in current implant research)? Will a bone graft be needed? Is there enough gingiva? Is the gingival margin visible at rest and in the animated states of speech and smiling? Alternatively, if the tooth is a posterior molar, function may be of greater significance. For example, is it a single molar in one quadrant? Additionally, for some teeth, root canal treatment may be quite challenging, and the cost for a highly trained specialist endodontist may not be much lower than the alternative.

It is also fair to ask whether patients are fully aware of the implications, and how much unbiased information is provided regarding the comparative issues surrounding such alternatives? For most patients, with limited knowledge of dentistry, asked to choose between attempting to save their own tooth versus extraction and implant placement, it is not surprising that they would choose the former; arguably an almost natural response. This is where the professional evidence-based judgement of the treating clinician, and their ability to communicate the risk/cost versus benefit analysis to the patient, becomes paramount. ■

1. Naini F B, Gill D S. Dentogingival aesthetics. *In* Naini F B. *Facial aesthetics: Concepts and clinical diagnosis*. Oxford: Wiley-Blackwell, 2011.

Interprofessional perio training – does it work?

Interprofessional enhanced skills training in periodontology: a qualitative study of one London pilot
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Health Education England developed a pilot educational and training initiative for enhancing skills in periodontology for both dentists and dental hygienists/therapists. The two-year programme began in 2011 at King's College Hospital and included one day of training per fortnight. This initiative was based on the concept of 'Dentists with Special Interests', which aimed to train practitioners working in primary care to provide supplementary services in addition to their generalist role, addressing the 'gap' between primary and tertiary care. An 'interprofessional model' was considered important as professionals are required to work in a team setting and a significant proportion of periodontal care is provided by dental hygienists/therapists.

This qualitative study explored the perceptions and experiences of those involved in initiating, designing, delivering and participating in this interprofessional approach to training. Semi-structured interviews were conducted with a sample of key stakeholders including the course participants, education and training commissioners as well as providers. The interviews were conducted towards the end of the two-year programme and based on a topic guide informed by health services and policy literature. Each interview was audio-recorded and transcribed verbatim.

A total of 22 key stakeholders participated in the interviews. Out of the 19 participants on the course, 12 agreed to be interviewed (four dentists and eight hygienists/therapists). Out of the 27 other stakeholders invited to participate, ten agreed, which included two representatives from Health Education England, one representative from Dental Public Health, six course educators and training providers, and one practice principal. NHS Commissioners of the training course did not respond and this was later acknowledged as a potential limitation of the study.

Although certain challenges were identified in designing and teaching a course bringing together different professional backgrounds and level of skills, the authors conclude that the experiences of all key stakeholders were overwhelmingly positive. There was evidence of 'creative interprofessional learning', which led to 'enhancing team working', 'enabling role recognition' and 'equipping participants for delivery of new models of care'. Recommendations emerged for future training initiatives, wider health policy and systems to enable participants on future enhanced skills courses in periodontology to apply these skills in clinical practice. The authors suggest that this model of training should be piloted for other aspects of dental care but emphasise the importance of taking on board the learning from this initiative. They recommend that evaluation processes should be built into future training to enable longitudinal evaluation from inception to end.

By Reena Wadia
BDJ Research Insights Team