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PSYCHOLOGY AS A TOOL FOR FOSTERING BETTER DENTIST PATIENT RELATIONSHIP: A PRACTICAL GUIDE

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ABSTRACT:. Why are some dental practices more successful than others? Skill, though undoubtedly important is not the complete answer.Simply put, a successful practice is directly proportional to the number of satisfied patients. And for a patient to be satisfied, it his needs that have to be met – voiced and unvoiced! Thus to be able to deliver effective dental care, needs as perceived by the patient and dentist need to be in sync. But to achieve this first and foremost a dentist must acknowledge the existent gulf that exists between professional and lay perception of needs and then proceed to bridge the gap between the two. This article looks at various ways in which the science of psychology can aid the dentist overcome this ubiquitous impasse. Psychology helps not only in assessing the underlying concerns of a patient but also in addressing them. And this in turn lays the foundation for a long lasting dentist-patient relationship which is what lies at the heart of any successful practice!

KEYWORDS: oral cancer, preventaion, curable

INTRODUCTION

Ever wondered why some of us have more successful dental practices as opposed to others? Could the answer be skill?

Skill though undoubtedly important is not the complete answer. The days of "drill 'em, fill ' em, bill 'em" definitely being over, a more sensitized approach is the need of the day!

A simple rule operates here, which says:
A successful practice is directly proportional to the number of satisfied patients. And for a patient to be satisfied, his needs have to be met – voiced and unvoiced! For when the dentist's perception of patient's needs are not in harmony with the patient's it gives rise to a dichotomy. A common example of this dichotomy is seen when there is little wrong with the clinical work but the patient remains dissatisfied.

DIFFERENCE IN PERCEPTION

Need as perceived by a dentist is related to professional knowledge and hence connected to a patient's physical dental health status only, whereas a patient's concept of need is influenced by psychosocial needs. Then again, the dental professional's perception of need for dental treatment remains fairly fixed but the need for dental care by a patient varies as it is pitted against more important life needs be they personal, family or social in nature. Thus translating symptoms into care will be different for dentists and their patients.[1] Patients, therefore do not just perceive their oral symptoms in physical terms but also with regard to their quality of life. In this way lay perspectives of oral symptoms can be thought of being analogous to a triangle of health being composed of physical, psychological and social dimensions.[2] And it is this clash between professional and lay perspectives which leads to unsuccessful treatment outcome and a disgruntled patient who might even seek legal redress.

SYNCHRONIZING PERCEPTIONS

To overcome this, first and foremost a dentist must acknowledge the existent gulf between professional and lay perceptions and then he must proceed to meet the perceived needs of the patient in order to provide effective dental care. Elinor Parker, Associate Editor of BDJ further moves this relationship from an adult-child one to one involving two equal adults and clarifies that "dental health care is a two person endevour, not something one person does to another".[3] Then again from a psychodynamic viewpoint dental healthcare is undoubtedly a 2-person endevour.[4] Thus to be able to deliver effective dental care, it appears needs as perceived by the patient and dentist should be in sync.

So should a dentist limit treatment only to 'needs' as perceived by the patient?

No, it is for the dental professional to make the patient aware of the dental needs as perceived by him and then try to motivate the patient to undergo treatment for what he feels is genuinely required.

EQUAL CONCERNS

Here it becomes necessary to understand that within the two-person endevour which is the dentist-patient interaction equal concerns are experienced by both the dentist and the patient.

Occupational stress acts as the main trigger for the dentist and the ability to acknowledge existence of stressors at workplace allows dentists to cope more effectively and prevent burnout. The idea that dentistry is the most stressful of all the health professions was first proposed by Cooper et al.[5,6]

On the other hand, reasons for patient anxiety are primarily rooted in the fear of physical pain. As historically dental anxiety has been attributed to the expectation of pain.[7] Uncertainty regarding outcome of the treatment, financial implications and the time involved are the other contributory factors that fuel anxiety. Being of the noble profession a dentist is supposed to provide care without thinking of the financial gain to self but sadly commercialization is so rampant today that this is always not the case. Well aware of this, it is not only the fear of physical pain but also the stress of guarding his hard earned money that is playing on the patient's mind, even as he steps into the office. The third factor could be worry pertaining to the end result both functionally and aesthetically. And of course, possibly the 'time' he would have to invest for treatment.

THE PSYCHOLOGICAL SOLUTION

Psychology not only helps in assessing the underlying concerns of a patient but also in addressing those concerns. And this in turn lays the foundation for a long lasting relationship between the dentist and the patient, which is what lies at the heart of any successful practice. And while both parties come to the table with their own peculiar set of problems, it is the clinician's responsibility to circumvent the erected barriers and effectively tailor the treatment to provide maximum benefit to the patient.

TRUST

Trust is one of the major cornerstones of this relationship and the onus is on the dentist to engender this feeling. A standard fee structure based on actual expenditure incurred and not on the patient's ability to pay does well to inculcate this. An honest and ethical approach works best as not only does it help build a good relationship with the patient, it also boosts the dentist's self esteem – making him feel good about himself. And at the same time cuts out the stress of thinking up fresh figures for every new patient. A clear understanding that one is in this for the long term and not just to make a quick buck helps to keep the focus.

EMPATHY

Empathy is the other major factor which helps nurture this relationship. A little empathy can go a long way with patients who due to a bad experience in the past are fearful and distrustful. But concern and care for the patient need to be genuine and not mere talk for feelings reach out and touch more readily than the said word. Posture, facial expression and tone of voice must never contradict what is said. Then again, a patient hands himself over to the clinician, entrusting him with his well being. And the health professional must prove worthy of that trust.

FIRST IMPRESSION

Now, it is the first few minutes of a dentist patient interaction that are critical as they set the stage for the future relationship. Carefully weighing up every word, the patient will be scrutinizing every expression of the dentist to form his first impression.

PUNCTUALITY

The first step is to be on time. It is important not to make the patient wait as time spent waiting fuels anxiety. It gives the patient time to think about what will happen and ponder the worst case outcomes. Besides punctuality always speaks well of a professional.

GREETING

Greeting the patient in the waiting room and escorting him into the office is a good first move for it demonstrates a personal commitment to caring. Also, this way the patient feels supported and hopefully maybe not so intimidated while walking into the dental office for the first time.

TONE

Low tone and paced speech convey confidence making a patient feel that he's in the right hands! And addressing him by his given name reassures him, as it is the only familiar sound in strange surroundings.

WORDS

Words are as potent as the medications used. So the same degree of caution must be employed. When a clinician says, ' you won't feel the pain'; the word 'pain' is all that stays in a patient's mind. Thus 'comfort' is the word that needs to be emphasized and not pain. Everyday

language must be used while describing the procedure to be undergone. Clinical sounding words trigger existing associations with being treated in a clinical and impersonal way. A 'new' word on the other hand reduces negative association.

WASTE OF TIME?

If a dentist feels he cannot afford to waste time in talk, it becomes imperative to understand that he CANNOT afford NOT to talk! So the first visit is the ideal opportunity to assess what the patient wants. And on his part the dentist must explain clearly – what is and what is not achievable. How long it will take. How it will look. How much it will cost. There should be complete clarity about everything related to treatment!

BARRIERS

It is during this visit itself that barriers to the recommended treatment or preventive care may surface. And some barriers of a patient's resistance to dental care may paradoxically originate with the dentist himself. Stress and anxieties together with a withdrawal of interest from work inhibit dental health professionals from providing accessible dental care for the patients.[8] Then again in general practice dental health professionals use advice to help persuade their patients to adopt preventive care. Patients hear the advise as critical and intrusive.[9] The patients resistance to change is increased and unhealthy behaviors reinstated.[10] A dentist's advise to adopt preventive action maybe taken by the patient as critical and intrusive leading to increase in patient's resistance and persistence of unhealthy behavior. A dentist on the other hand, finding his words ignored feels dental health education is a waste of time. Brief advise interventions thus end in impasse with patient and dentist retreating to previously held positions with respect to dental health education and the adoption of preventive actions. [11-13]
To get past this impasse, a dentist not only must understand the gap between the two perspectives – the patient's and his own, he must also endeavor to close that gap. Communication and motivation remain his two most effective tools in this venture.

COMMUNICATION

Communication is a two-way process in which verbal utterances and non-verbal cues are used within the dentist patient interaction. Psychological accessibility also relates to the dental health professionals ability to communicate effectively with patients. This ability has been shown to be greater in younger, more recently qualified dentists and in women dental health professionals.[14] These practitioners tended to listen more to their patients and attempt to provide care in keeping with the expressed needs of their adult and child patients.[15] The ability to achieve a balance between objectivity and empathy is the essence of effective communication.[16-18]

CLASS

The acronym CLASS is an effective communication tool[19,20].

C stands for the Context of the interview – In other words it refers to the physical setting. The aim being to provide an empathetic environment, the dentist while maintaining eye contact must at the same time ensure the patient is not made to feel uncomfortable by a continuous stare. Thus a good way out is to take down casual notes as the patient talks thereby keeping eye contact to a comfortable level. 65% of the communication being non-verbal, the first element of communication is an understanding of the patient's non-verbal cues. The body language should be observed keenly for the unsaid is as important as what is said and at times even more so.

L stands for Listening – Listening is one of the most active elements of verbal communication. If dental health professionals are to provide holistic health care and promote self-reliance in their patients, they must know their patients.[19] Although treatment decisions are founded upon clinical and objective criteria, there is evidence to suggest that doing do at the expense of listening to patient's feelings may lead to difficulties in diagnosis, patient management and subsequent non-compliance with treatment plans.[21] Therefore the aim of **active** listening is to engage, facilitate and encourage the patient to speak.[22] Not simply hearing words, it involves listening to the way the words are said, the feelings underlying and what has been left unsaid. Beginning with open-ended questions the dentist must listen attentively, allowing the patient to vent his feelings, fears and expectations of the treatment.
Then focused questions are used to maintain the impetus of the interview. These questions may also guide and support patients to express difficult thoughts about personal difficulties. And lastly come the closed questions or ending questions as they maybe termed. In essence they are yes/no questions that clarify points brought to the interview by the patient. They also help signal the end of the interview.

A stands for acknowledgement – A bad experience needs to be addressed not ignored. A dentist must acknowledge a patient's concerns. Concerns are directly related to a patient's comfort level and acknowledging them shows care. There is need to accommodate the patient's worries and fears concerning treatment itself and the outcome.

Here not only must the dentist acknowledge the patient's feelings but also his own, to the ongoing interaction. This acknowledgement will help him breakthrough any erected barriers. Showing empathy by reflective thinking using the patient's own words could help

clarify issues further. Fundamentally simple reflective thinking can be extremely effective as a tool.

S stands for strategy – Assessing the patient's treatment expectations the dentist may develop, propose and negotiate treatment and prevention plans. Explaining here would entail dental health advise given in a clear and concise manner restricted to three or four essential points expressed in simple language. This maybe given early in an interview and repeated several times.

Here again a dentist must have proficient motivational skills. The 'common sense' approach of motivating an adolescent to brush for fresh breath as opposed to oral health works every time! Making adjustments as and when the need arises the dental professional must gently guide the patient from unawareness to compliance. Carefully handled the patient will move through the stages of resistance to ambivalence and finally compliance or more simply from 'not ready' to 'unsure' to 'sure'.

S stands for summary – It entails the dentist summarizing the treatment and prevention options. As well as obtaining the final feedback. The practitioner knows the patient and can summarize the necessary clinical or health education information in a manner and in language the patient can understand. By making use of non-verbal communication[23] the dentist can be confident that the patient is agreeable to the negotiated way forward and has grasped the implications with regard to treatment outcome.[24]

4S

It is for this reason that anxious patients who must undergo restorative procedures are often managed using the "4S" rule which aims to reduce the triggers of stress.[25]

SIGHT Working in an environment on an everyday basis makes a dentist blind to what it actually looks like. So he needs to walk out of his surgery, clear his mind and walk back with curious eyes to see what a patient sees. Is there a lot of scary dental stuff lying around? This is what a patient sees! And a nervous patient is quite likely to assume that everything on the worktop is for use on them. While this is certainly not true! So why not remove the doubt by clearing the work surfaces as far as possible. Keeping the instruments in trays and out of sight works is a very good idea. Then again, the dental team wearing non-clinical clothes instead of the 'white coat' seems to help. As is said blue is the new white today!

SMELL The smell of eugenol and bonding agents can be pretty unnerving for a patient so one could try masking the clinical aroma by spraying scented oil fragrance.

SOUND AND SENSATIONS Sounds of drilling and high frequency vibratory sensations can be high annoyance factors too, which maybe substituted with techniques having reduced annoyance factors like atraumatic restorative technique (ART), ultra low speed cutting with polymer burs, chemo-mechanical caries removal, air abrasion or erbium lasers. And playing suitable music not only helps to drown out the unwelcome sounds but also serves to effectively distract the patient during an uncomfortable procedure.

TELL-SHOW-DO[26-28]

Further the classic 'Tell-Show-Do' method maybe used to empower the patient. Underlying this technique are the two important factors of rapport and control. Rapport being the primary requirement, it needs to be established before anything else. And the interactive and communicative approach of ' Tell-show-do technique is a great way of establishing this.

Tell: Explain what needs to be done.
Show: Show what it involves for example show the equipment and demonstrate it on the fingernail.
Do: Perform the procedure.

This technique needs to be used in conjunction with non-threatening simple language. The tell-show-do technique is actually a rapid form of desensitization where anxiety is reduced by a gradual acclimatization to objects that cause fear. Touch and interaction are central to it, providing a sense of control to the patient which cannot be obtained by 'just looking'!

A better term for this is the direct interaction technique as there is direct interaction of the patient with the dentist and the environment which gives rise to a sense of control and predictability thus reducing fear. This gradual approximation works really well for most people.

OTHER IMPORTANT FACTORS:

Control must be handed over to the patient by seeking permission before each new step. And giving choices – How do you want to sit? Should we start with this treatment or that? Gentleness rapidly inspires confidence as it is an important form of non-verbal communication. Thus a dentist must never forget to be gentle at all times. Teeth must never be knocked on carelessly with the mirror or prodded with the probe unnecessarily. Instead after explaining in advance what one is doing, the surface must be dried gently with air and inspected visually. A gentle touch on the shoulder when asking if everything is okay is very reassuring for most patients.

Time should be structured in such a way so as to take frequent breaks. Breaking up a procedure into short segments enables most people to cope better. In addition, a stop signal should be agreed on that allows a patient to stop treatment at any time. And the dental professional must respect that, otherwise the procedure maybe completed but the patient will definitely be lost. Being

flexible and demonstrating that he is willing to respond to a patient's needs helps build trust and confidence between the two.

It is communication that is at the very heart of helping the patient relax and feel okay with the situation. So the clinician must keep talking during the procedure, telling the patient what's going to happen next. For not only do well chosen words comfort, they also distract the patient and give him something to focus on, other than the ongoing procedure. Positive reinforcement or what is praise in plain English is another great way of communicating and providing support. Frequent praise and positive feedback go a long way in easing fears and if sincere act as powerful motivators.

CONCLUSION

The dentist patient relationship is far more important than was thought earlier and for the dentist to be able to translate symptoms into effective care, dental needs as perceived by the patient and the dentist need to be synchronized. But to be able to understand the needs and of course unspoken concerns of the patient the dentist would have to be mind reader….no?
Not really, for the branch of psychology can help provide a quick peep into the mind of the patient and all that the clinician essentially needs to understand is WHY the patient has come to the dental office.
Thus following the simple guidelines discussed above can aid the dentist patient relationship not only flourish but also grow. But what if the problem falls outside the dental professional's comfort zone? Well! Specialists are called in all the time to help out with other procedures, then why not a psychologist?

References

1. Freeman Ruth: The psychology of dental patient care: Reflections on professional and lay perspectives of the dentist-patient interaction. British Dental Journal 186, 546-550 (1999) Published online: 12 June 1999| doi 10.1038/sj. Bdj 4800166 http://dx.doi.org/10.1038/sj.bdj.4800166a1
2. Freeman R: The triangle of health: applications for general practice part 1 the clinical arena. Dental UpDate 1997; 24:61-63. PMid:9515354
3. Parker Elinor: The psychology of dental patient care: an introduction. British Dental Journal 186, 449 (1999) Published online: 8 May 1999 | doi:10.1038/sj.bdj.4800137 http://dx.doi.org/10.1038/sj.bdj.4800137
4. Freeman Ruth: The psychology of dental patient care: A psychodynamic understanding of the dentist-patient interaction. British Dental Journal 186,503-506 (1999) Published online: 22 May 1999| doi 10.1038/sj.bdj 4800152
5. Cohen LK: Converting unmet need for care to effective demand. Int Dent J 1987; 37:114-116. PMid:3476462
6. Cooper CL, Mallinger M, Kahn R: Identifying sources of occupational stress in dentists. J Occupational Psych 1981; 51:227-234. http://dx.doi.org/10.1111/j.2044-8325.1978.tb00419.x
7. SHARIF, Mohammad O. Guest Editorial - Dental anxiety: detection and management.J. Appl. Oral Sci. [online]. 2010, vol.18, n.2 [cited 2015-01-04], pp. i-i . Available from: <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1678-77572 010000200001&lng =en&nrm =iso>. ISSN 1678-7757. http://dx.doi.org/ 10.1590/S1678-7757201 0000200002
8. Burke FJT, Main JR, Freeman R: The practice of dentistry: a review of occupational stress and assessment of reasons for premature retirement. British Dent J 1997; 182:250-254. http://dx.doi.org/10.1038/sj.bdj.4809361
9. Freeman R: The psychology of patient dental care: strategies for motivating the non-compliant patient. British Dental Journal Sep 1999, Vol 187, pgs 307-312.Published online:25 sep 1999|doi:10.1038/sj.bdj.4800266. http://dx.doi.org/10.1038/sj.bdj.4800266
10. Barric L: Social expectations versus personal preferences – two ways of influencing health behavior. J Inst Hlth Educ 1977; 15:23-27.
11. Rollnick S, Kinnersley P, Stott N: Methods of helping patients with behavior change. Brit Med J 1993; 307:188-190. http://dx.doi.org/10.1136/bmj.307.6897.188
12. Butler C, Rollnick S, Stott N: The practitioner, the patient and resistance to change: recent ideas on compliance. Can Med Assoc J 1996; 154:1357-1362.
13. Stott N, Rollnick S, Rees M, Pill R: Innovation in clinical method: diabetes care and negotiating skills. Family practice 1995; 12:413-418. http://dx.doi.org/10.1093/fampra/12.4.413
14. Freeman R: The psychology of dental patient care: Barriers to accessing dental care: dental health professional factors. British Dental Journal : August 1999, vol 187:197-200.Published online: 28 August 1999|doi 10.1038/sj.bdj.4800238
15. Freeman R, Adams EK, Gelbier S: The provision of primary dental care for patients with special needs. Primary Dent Care 1997;4:31-34. PMid:10332344
16. Suchman AL, Markakis K, Beckman HB, Frankel R: A model of empathetic communication in a medical interview. JAMA 1997; 277: 678-682. http://dx.doi.org/10.1001/jama.1997.03540320082047
17. Ptacek JT, Eberhardt TL: Breaking bad news: A review of the literature. JAMA 1996; 276:296-502. http://dx.doi.org/10.1001/jama.1996.03540060072041

18. Hirschman SM, Htttleman E: Effective Communication. Gen Dent 1978; 26: 38-46.
19. Freeman R: The psychology of dental patient care: communicating effectively : some practical suggestions. British Dental Journal Sep 1999, Vol 187, Pgs 240-244.Published online: 11 September 1999| doi:10.1038/sj.bdj.4800251. http://dx.doi.org/10.1038/sj.bdj.4800251
20. Buckman R, Korsch B, Baile W: A practical guide to communication skills in clinical practice. New York. Medical audio visual communication Inc.1998.
21. Redford M, Gift HC: Dentist-patient interaction in treatment decision-making: a qualitative study. J Dent Educ 1997; 61:16-21. PMid:9024338
22. Kacpereck L: Non-verbal communication : the importance of listening. Brit J Nurs 1997; 6:275-279. http://dx.doi.org/10.12968/bjon.1997.6.5.275 PMid:9155278
23. Waitzkin H: Doctor patient communication: Clinical Implications of social-scientific research. JAMA 1984;252:2441-2446, PMid:6481931 http://dx.doi.org/10.1001/jama.1984.03350170043017
24. Calkins DR, Davis RB, Reiley P, Phillips RS, Pineo KLC, Delbanco L, Iezzoni LI: Patient-physician communication at hospital discharge and patient's understanding of the post discharge treatment plan. Arch Intern Med 1997;157:1026-1030. http://dx.doi.org/10.1001/archinte.1997.00440300148014
25. R Hmud, LJ Walsh: Dental anxiety: Causes, complications and management approaches. J Minim Inter Dent 2009; 2(1): 67-68.
26. Addleston HK: Child patient training. Fort Rev Chicago Dent Soc 1959; 38:7-9, 27-29.
27. Carson P, Freeman R:Tell-show-do: reducing anticipatory anxiety in emergency pediatric dental patients. Int J Health Prom & Educ 1998; 36:87-90. http://dx.doi.org/10.1080/14635240.1998.10806065
28. JF Roberts, ME Curzon, G Koch, LC Martens: Review: behavior management techniques in pediatric dentistry. European Archives of Pediatric Dentistry 2010 August; 11(4): 166-174. http://dx.doi.org/10.1007/BF03262738 PMid:20840826

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