

Review

Patient—dentist relationship

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The scope of the review has been confined to behavioral researches published mainly in the past two decades especially on patient-dentist relationship, dental anxiety, communication and patients' satisfaction. In summary, it is concluded that there is not so much progress during the period in the field of behavioral dentistry. Consequently, several recommendations are suggested for a future study of behavioral dentistry.

Key words: Patient-dentist relationship, Patients' satisfaction, Dentists' communicative style.

Introduction

Health care providers, such as doctors, dentists, and nurses, have long recognized that the patient's response to health care delivery (including satisfaction, commitment to prescribed regimens, and utilization of services) is closely related to how the patient perceives the quality of the provider-patient relationship^{1,2}. Perceptions of the quality of a relationship are essentially perceptions of the quality of communication between relational partners³. As a result, amount of research has been conducted on the manner in which physicians and patient communicate with each other^{4,5}. However, patient-dentist interaction has been largely overlooked by researcher⁶. The purpose of this paper is to review patients' satisfaction in relation to

the dentist's communicative style. Since patients vary in their expectations for the patient-dentist encounter, various subgroups of patients, such as males vs. females, worried vs. relaxed, first visit vs. repeat visit, older vs. younger, and more educated vs. less educated, may differ in their preferences for a dentist's communicative style⁷.

Ben-Sira demonstrated that patients evaluate the quality of health care in relation to their perceptions of "instrumental" and "affective" components of the provider's behavior^{8,9}. Instrumental behavior refers to the content or technical aspects of the provider's conduct, such as diagnosing, providing treatment, and reassuring the patient of the efficacy of his or her recommendations. Affective behavior, on the other hand, represents the provider's attitude toward the patient as a person and is manifested in the manner in which the provider interacts with patients, namely, the extent to which the provider allows sufficient time for the patient and displays an interest in and devotion to the patient's well-being. In another words, these two types of behavior can be closely related to 'cure' systems and 'care' systems, respectively. These two types of systems reflect patients' need for 'cure' and 'care' when visiting a doctor or dentist: 'the need to know and understand' (cure) and 'the need to feel known and understood' (care). Obviously, both are important features of provider-patient interactions. However, Because patients respond emotionally to their medical condition (e.g., due to uncertainty or to the perceived seriousness of the condition) and because patients have limited medical and dental knowledge (at least relative to that of the provider), patients will to a large extent rely on their perceptions of the provider's affective behavior to evaluate the provider's technical competence and the quality of health care received.

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Consistent with Ben-Sira's theory, research on the provider-patient relationship in a medical context⁸⁻¹¹ and in a dental context¹²⁻¹⁴ has repeatedly demonstrated that patients' response to health care delivery (e.g., satisfaction, anxiety, and utilization of services) are strongly influenced by the patients' perceptions of provider's attitudes toward the patient, including concern, interest, supportiveness, friendliness, and so on.

Interactants' attitudes toward partners are revealed in their communicative "styles," or in how they communicate with each other and, also important, in how they perceive each other's communicative responses^{15,16}. For example, when communicating with the patient, the dentist verbally and nonverbally sends relational messages such as concern or aloofness, friendliness or hostility, formality or informality, superiority or equality, and whether conversation is for the task or for social purposes^{3,17}. Thus, an important question for empirical study is to identify what features of the dentist's communication with patients influence dental outcomes. In particular, two dimensions of a dentist's communicative style-communicative involvement and dominance-appear particularly salient to the patient's response to dental treatment (Table 1).

Patients' Satisfaction and Dentists' Communicative Style

Communicative involvement refers to the extent to which an interactant displays attentiveness, perceptiveness, and responsiveness toward his or her partner (18). Highly involved interactants listen attentively, show concern, solicit the views of others, produce empathic and supportive utterances, and are willing to discuss the conversational topics of partners^{19,20}. Several studies have reported that patients' perception of dentists' behaviors and attitudes indicative involvement are strongly related to dental outcomes. For example, Corah and his colleagues have found patients' satisfaction and the reduction of dental anxiety to be positively related to patients' perceptions of the extent to which the dentist encouraged questions, paid attention, had a calm manner, was friendly, took them seriously, and was reassuring¹²⁻¹⁴. Similarly, Rankin and Harris reported that patients in their study preferred dentists who explained treatments fully and who acknowledged patients' cooperation²¹.

Communicative dominance represents the degree to which an interactant dominates the interaction and seeks to control the behaviors and opinions of partner's¹⁶. Dominance is typically manifested in behaviors such as conversational floor time, interruptions, criticism, loudness, gaze aversion, and directives²². Two

Table 1. Items Assessing Patients' Perceptions of Dentists' communicative Style Communicative involvement¹⁸.

1. The dentist listened carefully to you.
2. The dentist was very observant during his or her conversation with you.
3. The dentist was responsive to what you said and what you needed.
4. Often the dentist was unsure about how he or she was expected to respond
5. The dentists' mind seemed to wander and he or she often missed parts of what was going on.
6. The dentist did not know what you were really saying.
7. The dentist really knew what was going on; that is, he or she really had a handle on the situation.
8. Often the dentist was not sure what your needs were(e.g., reassurance, support, etc.) until it was too late to respond appropriately.
9. The dentist could accurately perceive your intentions quite well.
10. The dentist paid close attention to what you said and did and tried to obtain as much information as he or she could

Communicative dominance¹⁶

1. When the dentist disagreed with you, he or she was quick to challenge you.
2. The dentist was dominant in the situation with you.
3. The dentist was very argumentative.
4. The dentist tried to take charge of the interaction when he or she was with you.
5. It would bother the dentist to drop an argument that was not resolved.

Note: These items were, of course, randomly ordered in the response form.^{16,18}

studies have reported that patients generally responded negatively to dentists who criticized patients^{12,21}.

These findings suggest that patients prefer communicatively involved and nondomineering dentist and are consistent with analogue research findings in the case of physician-patient in medical context^{4,20, and 23}. These preferences can be understood within the context of several characteristics of the provider-patient relationship. First, as mentioned earlier, patients are largely dependent on the provider's expertise and technical skills for treatment and medical judgments⁹. Second, patients often experience a variety of emotions (e.g., anger, fear, and depression) due to uncertainty and anxiety about their medical/dental condition and treatment^{24,25}. Therefore, it is not surprising that patients want health care practitioners who express an interest in and concern for the patient, who are empathic, who take the patient seriously, and who demonstrate a commitment to the patient's well-being^{11,13}. The attentive and responsive nature of a communicatively involved doctor likely evokes these perceptions. Finally, due to their desire to gather information, to share their concerns, and to express their preferences for treatment, patients generally prefer to be active participants in the medical encounter^{1,26}. If a provider is dominating the content and nature of the interaction, the patient may not have the opportunity or the inclination to ask questions, express opinions, and so forth. Thus, it was hypothesized that patients' perceptions of dentists' communicative involvement and negatively related to perception of dentists' communicative dominance. Although these relationships may emerge generally, there is a possibility that different types of patients may vary, perhaps dramatically, in their preferences for a dentist's communicative style. For example, although not specifying a particular group of patients, Rankin and Harris observed that a noticeable percentage of patients are comfortable with authoritarian dentist's²¹. Likewise, some patients may need more communicative involvement from dentists than do others. Several patients' characteristics (including dental anxiety, previous visits with the dentist, sex, age, and education) conceivably mediate relationships between patients' satisfaction and perceptions of the dentist's communicative style.

Dental Anxiety

Fear of dental treatment is a major factor influencing patients' attitudes toward dentists and decisions to seek dental care^{27,28}. Rankin and Harris observed that, relative to number of high-fear patients, more low-fear patients thought their dentists explained treatment fully and rarely scolded²¹. Although dentists in the study were perceived responsive to the needs of anxious patients, it does not answer the question of whether responses to a dentist's communication vary as a function of the patient's anxiety. Some insight into this issue is provided by research on physician-patient communication.

Street and Wiemann reported that patients who were worried about their medical condition expressed greater satisfaction with more interpersonally involved physicians and were more tolerant of communicatively dominant doctors than patients who were less worried²⁰.

Other research has revealed that, relative to patients with minor conditions, patients with more serious ailment depend more on affective features of the physician's style (i.e., care, concern, and interest in the patient) when assessing the quality of health care received⁹. In summary, worried patients may prefer more substantial communicative involvement from health care providers in order to alleviate their anxiety, to gain adequate information about the condition or treatment, and to be convinced of the provider's commitment to their well-being. Also, relative to patients who are less fearful, anxious patients may be more tolerant of the provider's efforts to dominate or "take charge" of the interaction due to their fear and uncertainty about the medical condition or procedures.

First-visit Versus Repeat-visit Patients

When first interacting with another person, conversants tend to base their impression of partners on the partner's communicative behavior, or on how he or she talks and acts. After developing a relationship, however, interactants' impressions are grounded less in the surface features of the other's communicative style and more in their shared past experience³. Applying these notions to the provider-patient relationship, new patients are likely "hyper attentive" to the manner in which the health care provider communicates with them²⁵ and will assess the quality of health care received in relation to ostensible features of the

provider's behavior. On the other hand, repeat patients, can recall previous experiences with that particular provider to gauge the quality of care received. Thus, repeat patients may be less concerned about the doctor's communicative style itself. Two studies have reported that repeat patients indeed were more tolerant of physicians' communicative dominance than were new patients^{20,23}. DiMatteo and Hays also discovered that the longer a patient had been with a particular physician, the less important were perceptions of the physician's personal style as a determinant of the patient's satisfaction¹⁰.

Patients' Education

Rankin and Harris found that a larger percentage of patients having a high school education or less perceived their dentists as being more informative about treatment and more truthful about pain than did patients having more education²¹. However, this study did not reveal whether patients of varying education levels different in their reactions to a dentist's communicative style.

In medical settings, Ben-Sira supported the proposition that, because they typically have less health information than do more educated patients, less educated patients rely more on the physician's affective behavior and less on the physician's technical competence when evaluating the quality of health care than do more educated patients^{9,29}.

In a related study, DiMatteo and Hays reported that the correlation between patients' satisfaction and perceptions of the physician's technical competence was indeed stronger for patients of high socioeconomic status (SES) when compared to low-SES patients¹⁰.

Patients' Sex and Age

In general, women tend to be more satisfied with health care than are men³⁰, perhaps because female patients typically receive more explanations, more information, and more time from physicians than do male patients³¹. One study reported similar findings among dental patients²¹. However, whether male and female patients differ in their preferences for dentists' communicative involvement and dominance remains uncertain. In medical settings, Street and Wiemann found women to be more satisfied with highly involved physicians than men were²⁰. Other studies, however,

have responses to health care providers' communicative styles^{10,21,32}.

Regarding age, patients under 24 years of age have self-reported greater tolerance of dentists who did not explain procedures before beginning treatment or who scolded them for poor oral hygiene than did older clients²¹. This finding suggested that younger patients experience greater satisfaction with less involved and more authoritative dentists than do older patients. However, this notion has not been tested in dental settings and has not been supported in medical contexts. Three studies have reported statistically insignificant associations between patients' age and preferences for physicians' communicative style^{9,20,32}, whereas one investigation discovered that the commitment to therapy by patient over 55 years of age was less dependent on how well the doctors listened than it was for patients younger than 55¹⁰. Thus, specific predictions cannot be justified regarding relationships between a patient's sex, age, and reactions to a dentist's manner of communicating.

Concluding Remarks

Sondell and S_nderfeldt pointed out that a theory of communication is lacking in the dental context and proposed "a model for encounters in dentistry" (Fig.1). Therefore, it is suggested that development of a reliable and valid interaction analysis system for the patient-dentist communication should be necessary. In addition to this system, for the future researches, some recommendations can be given as follows;

1. Research should be more experimental, instead of descriptive or explorative.
2. Instead of confirming and reconfirming existing knowledge, scientists should try to really add something novel to the body of knowledge.
3. Cooperation among dentists, co-dental staff, and psychologists should be further strengthened, combining the theoretical background and methodological knowledge of psychologists and the dental knowledge and access to clinical settings of dentists.
4. Cross-cultural difference in communication process between dentists and patients should be considered.

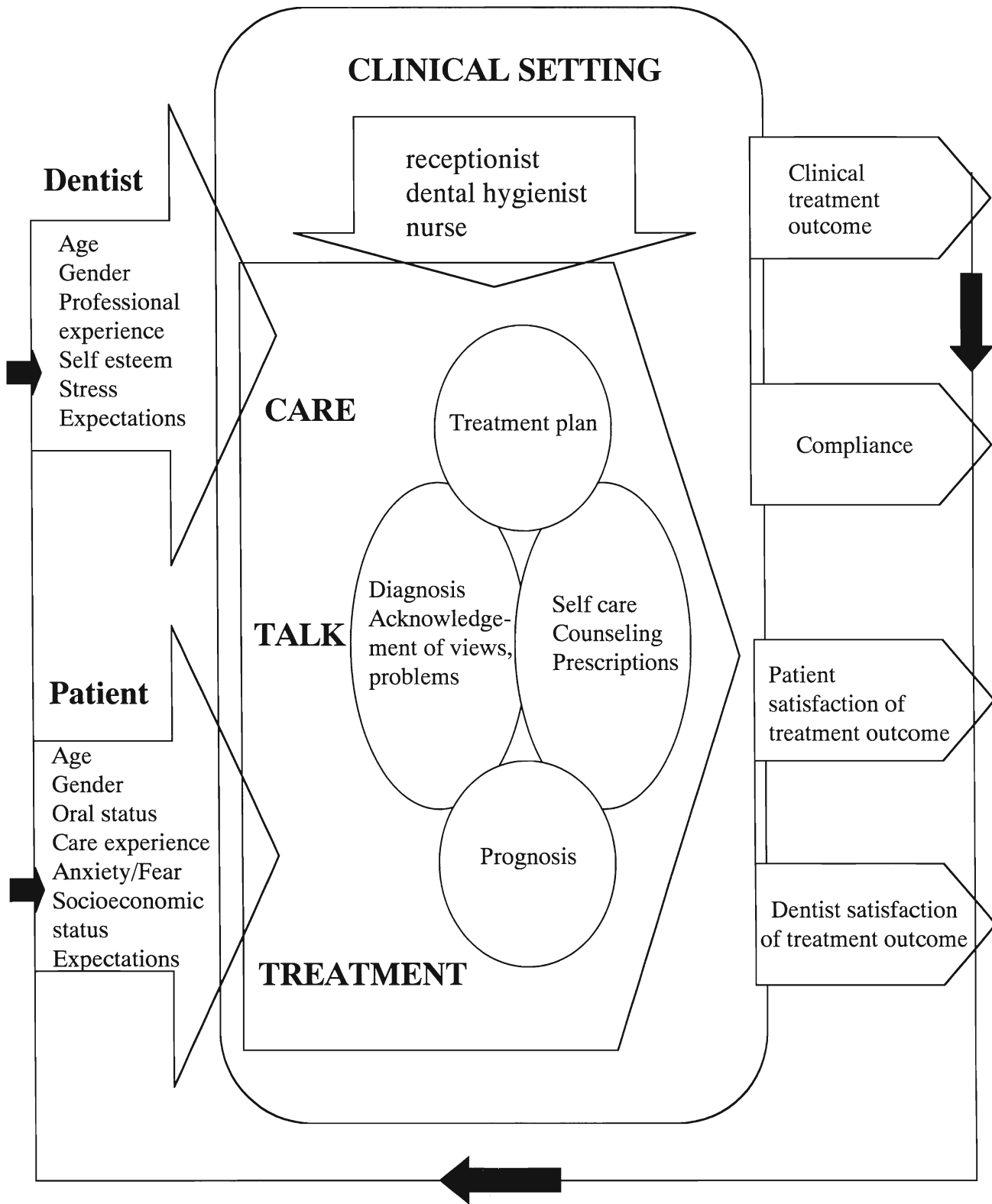


Figure 1. A model for encounter in dentistry³³.

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