

# Practice Management Forum

## Patient Co-operation—How can it be Improved?

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**Abstract.** *This paper considers ways of improving patient co-operation. It is divided into two parts. Firstly, communication with the patient (i.e. the child and their parents) and secondly, the use of simple reward charts that are relevant to orthodontics.*

**Key words:** Co-operation, Orthodontics, Doctor–patient communication, Reward charts.

A co-operative patient is an essential element of successful orthodontic treatment. The literature on co-operation also refers to compliance and adherence. In this context, these three words are interchangeable, but only co-operation shall be used in this paper. Most of the research on co-operation has been carried out in the USA, where orthodontists are advised that a good rapport with their patient is cost effective because it minimizes malpractice suits (Barbat 1992). This illustrates one of the main differences which still exists, between the practice of orthodontics in the USA and Britain. Another major difference, which is specifically relevant in the context of discussing patient co-operation is that all American orthodontic treatment is carried out under private contract. Despite these differences there are still many points which are pertinent to the practice of orthodontics in Britain.

Patients are more likely to co-operate with orthodontic treatment, if they are satisfied with the way in which their orthodontist communicates with them and if the orthodontist decreases their anxiety (Sinha, Nanda and McNeil 1996 and Corah, O'Shea and Bissell 1988). Co-operation has been examined in terms of patient's keeping their appointments, wearing their elastics, headgear or functional appliances, keeping their teeth clean and refraining from chewing substances which will distort their archwires or de-bond their brackets. Eight important factors have emerged from this research. Many orthodontists, reading this article, will probably be carrying out at least six of these already in their routine practice, but may not be aware that there is good research which provides support to this approach.

1) *Being polite, friendly and making the patient feel welcome.* Remember that making the patient feel welcome means making the child *and* parent welcome. Parents are generally put at their ease if staff are friendly and polite. Information also helps particularly about who they will be seeing (e.g. having a board with photographs of 'Who's who' at the practice) and how long they will have to wait. They will also be put at their ease if their child is happy. In the waiting area, it is important to have toys and magazines appropriate to the age of the children. This means that if you are mainly seeing young adolescents you should have

copies of 'Just 17', 'Posters' and football magazines not cuddly toys.

- 2) *Having a calm, confident manner.* This means that even when your nurse is off sick and you are running late, you remain calm during your time with the patient. Being confident does not mean that you have to know the answer to everything, but if you do not know you put that across confidently e.g. 'I don't know the answer to that, but I shall ask Mr. X and I'll let you know at your next appointment'.
- 3) *Giving information about the problem, the proposed treatment plan and the procedure you are going to perform.* Remember, it is important to talk to both the child *and* their parent. Children feel more at ease if you speak to them in a pleasant and relaxed manner. As for parents, research shows that five minutes after a consultation only 50% of the information is recalled. It is more likely to be forgotten if the person is anxious and advice and instructions given at the end are forgotten more easily. (Korsch and Negrete 1972) Giving written information to back up the verbal communication is very helpful, but do not give it at the expense of speaking to the patient.
- 4) *Not using jargon.* Sometimes, it is hard to recognize when you are using jargon, particularly when you have become very familiar with the terminology. It is important to check that the parent has understood because you need to rely on the parent to reinforce the right message and provide you with the required support. In one study the doctor told patients they could not take substances containing Aspirin. Of the patients, 9% thought Aspro was safe, 17% thought Disprin, 20% thought Anadin and 72% thought Alka Seltzer! This example shows just how careful you need to be, in relaying information to your patients. You cannot presume your patients understand what headgear or oral hygiene is and you must therefore be specific about the sorts of foods they should not eat. Using photographs of the various appliances can ensure that you all have a common understanding.
- 5) *Paying attention to what the parent and child says.* There is a need not only to speak and give lots of information but also to actively listen. Active listening means letting someone know you are listening—by nodding your head, looking at them and saying things

like 'uh huh'. It also means not interrupting or jumping to conclusions but asking questions to clarify that you have understood what the speaker is saying. It is important to use both open and closed questions. Open questions make parents feel they have had an opportunity to speak i.e. asking questions which start with how, what, why that require more than a one word answer. Closed questions can be used to wind up a conversation and are questions which only require a one word answer e.g. 'Have you brushed your teeth this morning?' or 'Have you worn your headgear?'

- 6) *Reassuring the child that you will do everything to prevent pain.* You should ask the child to let you know if any of the procedures are painful. If the child does let you know then it is important to stop and adjust the procedure or explain how long this part will take and continue when the child is ready. You can explain that when they first wear a new appliance this may be uncomfortable, if this becomes too painful they can return before their next appointment so you can adjust it and make them comfortable.
- 7) *Express concern about the child's well-being.* This means inquiring how the child is and if they tell you that their teeth were sore for a week after the last appointment you should show sympathy and reassure the child that this time and you will try to make absolutely sure that it does not happen again. However, be honest and if it will be painful explain why and for how long they can expect discomfort.
- 8) *Do not criticise the child's tooth brushing or oral hygiene.*

Criticism has a strong link to poor co-operation. Encouraging a child to improve their tooth brushing, is more effective than criticism.

Nanda and Kierl (1992) showed that with patients who were co-operating poorly, if communication between the orthodontist and the patient improved so did the co-operation.

They measured co-operation in terms of the patient's attendance at appointments, appliance maintenance and their use of their removable appliances. They came to a tentative conclusion that orthodontists may tend to blame the patients rather than themselves when the treatment is not going well.

Most of these suggestions are common sense but may seem time-consuming. However, the time required to establish a good rapport with a patient is less than the time required to correct the difficulties that result from a patient who is co-operating poorly (Sinha, Nanda and McNeil 1996).

It is important to remember that your patients are people with malocclusions not malocclusions with people attached to them. Acknowledging this single fact alone, will help to improve your patients' co-operation.

### Simple Reward Charts

These can be used in many situations e.g. to help a child stop sucking their thumb, to encourage a child to wear a functional appliance or headgear and to improve oral hygiene. Reward charts may at first seem very time consuming because they need to be tailored to the indi-

vidual. To follow are some basic guidelines, in which encouraging a child to wear a functional appliance is used as an illustration.

- 1) *Establish a baseline.* You need to find out how long the child is wearing their functional appliance. Provide the child with a simple chart (See Fig 1) and ask them to record accurately the times that they wear their appliance. You could also ask them to note down why they took their appliance out. Cureton, Regennitter and Yancey (1993) have shown that children who were given headgear charts complied better than children who were not. They used headgear timers concealed within the headgear strap and showed that just being given a chart and being asked to record has a positive effect. The study also showed that the records were an accurate reflection of how long the child has actually worn their head gear.
- 2) *Set the reward at an achievable level.* If the child is wearing their appliance for 6 hours and you want them to wear it full time, the first goal would be 7 or 8 hours. This is not the final goal, but you gradually move the child towards the final goal of full time wear by increasing the time once they have achieved the first target. At the end of each day that they achieved their target they could put a sticker on their chart. The child needs to be provided with a new chart and appropriate stickers e.g. football stickers or 'Disney' stickers. Letting the child choose from a selection can be effective.

Reading the child's notes on why they are removing their appliance is important. You may well be able to increase the time they are wearing it just by giving information or re-assurance. For instance, re-assuring a child that their speech will only improve if they practise talking whilst wearing their appliance will make a difference.

- 3) *Decide on rewards.* Rewards are individual to a child and need to fit in with family values. A certain number of stickers can add up to a reward. Again this number must be set at an achievable level. A reward for one child may be to be taken roller blading, or having a couple of friends for a sleep over or going to MacDonaldis, or even extra pocket money. The child and parents need to decide on appropriate rewards.

Depending on the child's age and inclination, additional praise may be rewarding. Again this is individual to a child and needs to be asked about and not presumed.

If it is rewarding then putting the chart up in the kitchen and getting relatives and friends to comment on it can increase the charts effectiveness.

- 3) *Giving a child their own individual package, will make them feel important.* If you do not have time to draw out the chart, you can still give a large piece of paper, some stickers and a sample chart with some guidelines and suggest they go home and make their own and bring it with them to their next appointment.

It is important that if you are asking a family to put in this much effort that you remember to look at it at the beginning of their next appointment.

These ideas can be adapted to improve a child's oral hygiene or to decrease their thumb sucking habit.

BASELINE CHART

Date						
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
Why Appliance was removed						

In the upper boxes please record the times that the appliance was worn and in the lower boxes the reason it was removed

FIG. 1

**Conclusion**

When a patient is co-operating poorly, the first step is to examine whether you can improve the way in which you are communicating with the child and their parents. You could also give the child a chart to record their use of their appliance or you could follow the above guidelines and set up a reward system. If these steps are followed, you should be faced less frequently with the need to abandon orthodontic treatment.

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