Editorial

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Measuring outcomes has long been championed in healthcare research. In recent years, patient reported outcome measures (PROMS) have been extensively used as a primary means of assessing the outcome of treatment from the perspective of the stakeholder – the patient. However, the focus is now shifting from measuring outcomes exclusively to also measuring experience. We have all heard the old adage, the journey is more important than the destination, and it seems that this may well be true for healthcare. There is evidence that where patients are partners in their healthcare journey, outcomes are better; from both objective and subjective perspectives (Stewart *et al*., 2000).

Patient-centred care (PCC) is a fundamental concept at the heart of modern healthcare. PCC involves delivering care that takes into account an individual's needs, preferences, and values (Institute of Medicine, 2001). It replaces the traditional paternalistic 'doctor-knows-best' approach and has become a priority for the National Health Service in the UK and many other countries (NHS, 2014; World Health Organisation, 2016).

Communication and information provision are key elements of PCC. There is an emerging body of evidence to suggest that putting patients at the core of their healthcare improves satisfaction, outcomes and, interestingly, may reduce the burden on overstretched public services as patients tend to make more conservative choices than healthcare professionals (Stewart *et al.*, 2000; Goodrich *et al.,* 2008). In this era, where there is an increasing obligation to justify services, the practice of PCC is becoming even more important, as is research investigating this concept.

This brings us to the article by Catt and colleagues in this issue of the Journal of Orthodontics (*Quality of life and communication in orthognathic treatment*, ref in journal). It is encouraging to read this well-written, timely article that explores the relationship between communication (a key element of PCC) and oral health-related quality of life (a PROM). This was a multi-site cross sectional questionnaire study carried out in the UK with two aims:

1. To determine if patient-clinician communication affects oral health-related quality of life (QoL) in individuals who have completed orthognathic treatment, and
2. To assess if there is a difference in oral health-related QoL in patients before embarking on orthognathic treatment and those who have completed it.

The study was conducted in 4 different orthodontic units; 73 patients were recruited in the pre-treatment group and 78 in the 2 year post-surgery group. All participants were asked to complete the Orthognathic Quality of Life Questionnaire (OQLQ, Cunningham *et al*., 2000, 2002), which is the most commonly used condition-specific measure to assess oral health-related quality of life in individuals with dentofacial deformity. In addition to this, participants in the post-surgery group were asked to complete a questionnaire assessing their perceptions of the quality of communication provided by the orthognathic team and support staff. This questionnaire was the Communication Assessment Tool – Team (CAT-T, Makoul *et al*., 2007, Mercer *et al.,* 2008) which measures the quality of communication from the patient's perspective

The results revealed, unsurprisingly, that patients who had completed orthognathic treatment had better oral health-related QoL than those about to embark on treatment, as has been reported widely previously (Hunt *et al.,* 2001; Motegi *et al.,* 2003; Alanko *et al.,* 2010; Soh & Narayanan, 2013).

With regards to communication, it was interesting to note that those who had a better QoL also rated their communication with the team as superior and communication was rated as 'excellent' in most domains. The lowest ratings were for the items asking about front desk staff, clinicians encouraging patients to ask questions, involving patients in decisions, and clinicians showing interest in patients' own ideas about their health, although the mean scores for these were still high at 67-68%. It is important to note, however, that these are key aspects of PCC, therefore they are areas which should perhaps be the main focus when considering enhancement of healthcare services.

The authors clearly highlighted the limitations of this study; as it was cross-sectional and not longitudinal in design, it is not possible to establish causality. Although individuals who received orthognathic treatment had higher quality of life than those who had not, this may have been due to other confounding factors. In addition, although a relationship existed between higher QoL and better patient-clinician communication, an association or direction of effect cannot be proven from the current study. Nonetheless, this research provides a valuable starting point from which to extend our knowledge base of communication and patient-centredness in orthodontics.

So why is any of this relevant to us and our everyday practice? Evidence has shown that if we are communicating well with our patients, they are better informed and, this in turn ensures that consent is more valid. Patients who are more involved in their treatment decisions have also been found to show better adherence and are more satisfied with treatment outcomes. Of course, satisfied patients usually lead to satisfied clinicians so this is an important aspect for all involved!

Although it makes sense intuitively that patients should be the drivers in their treatment journey, there is increasing evidence that not *all* patients want to be in that role (Coulter, 2002). Some individuals prefer to defer to the knowledge and experience of a clinician they trust to help them arrive at their destination. The concepts underlying PCC make clear that either way is fine - what is important is that we, as clinicians, ask our patients what *they* want and not assume to know.

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