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Reputation of Oral and Maxillofacial Surgery in the UK: the patients' perspective

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ABSTRACT

The contribution of this study is to shed theoretical and practical light on the professional reputation of Oral and Maxillofacial Surgery (OMFS) in the UK by drawing on theories from the management literature, especially reputation management. Since professional reputation is socially constructed by stakeholders, we used interpretivist methods to conduct a qualitative study of patients to gain insights into how the view the profession. The findings from our focus groups highlight the importance of 'soft-wired skills' and shows a perception-reality gap in patient-doctor interaction. They also highlights the importance of message consistency, relational coordination, transparent feedback mechanisms and professional governance processes. In addition, the role of the media and the Internet in professional reputation was explored to help understand the proposed strategic steps that OMFS may use to enable better management of its reputation.

The problem

The concepts of profession and reputation are inextricably interlinked in public consciousness and professional practice in medicine.[1] In this paper we seek to understand in greater depth the problems associated with enhancing the professional reputation of OMFS, which, in common with other medical specialties, is facing a number of challenges. Not the least of these challenges is that professional reputations are gifted by salient stakeholders rather than being in the direct control of professionals themselves.[2] One of the most important of these stakeholders are patients who have been seen in the literature on professions in medicine as an important cause of feelings of deprofessionalisation.[3]

OMFS in the UK has been subject to 'political shifts' from a dental to a medical base. In the late 1980s OMFS was recognised as one of the 10 surgical specialties, regulated by the General Medical Council (GMC), and represented by the British Association of Oral & Maxillofacial Surgeons (BAOMS).[4] OMFS is "unique" as practising specialists must obtain accredited GMC and General Dental Council (GDC) qualifications . There are approximately 156 OMFS units across the UK with approximately 300 OMFS consultants and 120 specialist trainees.[5]

The economic case for OMFS becoming a medical rather than a dental profession has been a controversial subject. In the UK, it is argued that the bulk of OMFS workload (dentoalveolar surgery) can be carried out by dentally qualified oral surgeons who are

'cheaper' to train (6-8 years) rather than the more expensive 16-20 years required for training of an Oral and Maxillofacial Surgeon. Some elements of the medical elites support this economic argument, but others argue that the quality of care delivered by a dual qualified OMF surgeon, who is able to deal with both simple and complex surgery, is a price worth paying for health outcomes. A recent Postgraduate Medical Education and Training Board (PMETB) review[6] vindicated the latter view, that although OMFS training is lengthy, the overall long-term benefits are demonstrable.

Nevertheless, there still remains a marked degree of overlap in the scope of practice of OMFS with other surgical specialties particularly Plastic Surgery and Ear, Nose and Throat (ENT) and Dentistry. Furthermore, confusion has been created for patients and the public by inconsistent terminology, since OMFS is variously referred to as Oral Surgery, Oral & Facial Surgery, Oral and Cranio-Maxillo-Facial Surgery. Thus our focal research question is: how do patients view the claims to professional status by OMFS and how should the profession address these perceptions to enhance its reputation?

Methodology

We adopted a phenomenological approach to the project to explore the perceptions and worldviews of patients, who are key stakeholders in creating a professional reputation among OMFS. The chosen research technique was focus group interviews to gain insights into patients' insights into the complex notion of reputation in interaction with other patients.[7]

Adult patients fulfilling selection criteria (Table 1) who attended the Outpatient Department of OMFS at the John Radcliffe Hospital, Oxford were invited to take part in the . Interested participants provided their contact details and received an information pack.

Inclusion criteria	Exclusion criteria
• Ability to give informed consent • Male or female, aged 18 years or above. • Attending the Department of OMFS at John Radcliffe Hospital. • Good command of English language.	• Inpatients • Emergency admission • Those younger than 18 year old. • Incompetent patients. • Inability to communicate in English language. • Patient who declined participating in the study. • Patient who attending other departments of the hospital.

Each focus group consisted of at least 5 and a maximum of 10 patients, with each session lasting for a maximum of 90 minutes. A representative mix of gender, age, educational, and socio-economic background within each focus group was encouraged in order to obtain maximum variation of views. Each session was started with a statement on confidentiality, and written consent was obtained. A subset of five questions was used to explore the focal areas of the study (Fig 1). Sessions were digitally recorded, then transcribed verbatim and typed to eliminate memory artefact and inaccuracies in data collection. The study was approved by the Law and Business School Ethics Forum at the University of Glasgow, and the National Research Ethics Committee South Central, Oxford

A total of 17 patients (10 women and 7 men; with age ranging from 20 to 73 years) participated in focus group discussions. Thematic analysis was used to identify

common themes that emerged during the discussions, supported with relevant quotes of participants and theoretical principles learnt from the literature.

Figure 1. Interview Schedule

Question 1: What makes a group of people professionals?
Provoking points: Practising high moral standards? Specific skills and knowledge? Responsibility to the society?

Question 2: In business and marketing, reputation is used to convey quality. Do you think it is important that a profession has a reputation? If so, what should that reputation be?
Provoking points: Can the notion of reputation in the private sector be transferred to medical profession and if so how? Why this can be important? Recruitment, contracting to service, funding? Research? Political influence?

Question 3: What comes to mind when you think about what reputation in of a branch of medicine?
Provoking points: Explore patient's understanding of the term profession and Oral & Maxillofacial Surgery.

Question 4: What characteristics would reflect a good professional reputation in Oral & Maxillofacial Surgery? How would these characteristics be conveyed to public?
Provoking points: Facilities, staff, communication, and team working. State of the art treatment? Minimal waiting time? Transparency? Financial performance? Strong research foundation? Strong media presence? Presence on the Internet?

Question 5: Does the Internet have an impact on the reputation of a profession? Do you have access to Internet? Have you used the Internet to gain information about OMFS? What impression do you have of OMFS and how was this formed?
Provoking points: Quality, ethics, access.

Findings

The following themes emerged from our data.

The importance of consistency

Consistency, reliability and predictability are the cornerstones for creating long-term relationships with stakeholders.[8] In OMFS, there are three reasons for such inconsistency; the overlap with other surgical specialities; the variety of names used to describe OMFS, and the 'unattractive' names of the speciality which patients and the public find "meaningless", difficult to understand, and to remember.

"*... the fact that your name is difficult to pronounce, doesn't make sense to people. If you have a name that doesn't really make sense in your head you won't remember it*"

Patients preferred a clear scope of practice and a meaningful 'user friendly' name that has an impact. Consistency reflects high professional standards of good work ethics. Inconsistency creates a sense of confusion, and leads to unpredictable standards with 'inconsistent' relationships with stakeholders likely to be perceived negatively.

Unique nature of OMFS

OMFS is unique among medical specialities because it requires dual qualification,[4] which in this study was perceived negatively by patients. Dentists were less well regarded than medical doctors. Some patients reported the dental qualification offers no advantage or uniqueness but rather compromises the reputation of OMFS to some extent.

"*... So I think dentists aren't regarded in the same light as doctors, is what I'm trying to say. So when you've got a combination of a dental doctor you might be slightly pulled down by the dental side...I'm saying they are professionals but they are also running a business and its money orientated rather than health orientated*."

The concept of a profession

Hard-wired skills

Facets of the medical profession are subject to cultural, political and social changes.[9] There are strongly engraved, measurable characteristics that distinguish medical professionals from other sections of society, which we label and 'hard-wired'. Although special skills, knowledge in a particular field, lengthy years of education and training were frequently referred to by participants, from the patients' point of view two distinctive features must apply to a group of individuals in order to classify them as 'professionals'; qualifications granted by highly respected organisations and a clear code of conduct or accountability that is governed by a regulatory body.

"*People who claim to have a profession should have special qualification that comes with years of education and training and also should have some code of conduct or regulation. That what makes doctors…doctors, and plumbers …plumbers.*"

Soft-wired skills

Unlike hard-wired characteristics, soft-wired skills are difficult to measure, and refer to socio-psychological aspects such as bedside manner and people skills. Patients reported trusting competent and skilled doctors to treat them, but they also put great emphasis on two main intangible domains, which were communication and team working, and good interpersonal skills, including bedside manner, empathy, sympathy and emotional intelligence.

"*I totally agree. There is more, a kind of….hmmmm, to surgery or medicine than technical skills and knowledge. Doctor must have good people skills and be able to connect or relate to patients. I remember when I was in the hospital, doctors used to come in their morning round and talk to each other about me and go….ignoring me. No one seemed to bother explaining to me what is going on or how I was doing!*"

Team working was also seen as likely to create a favourable environment that encourages new ideas or approaches that may ultimately benefit patients.

"*Team work also I would say is something which would take the person towards a higher level as well because cross ideas may help the individual to achieve higher goals in life.*"

Reputation and clinical outcome

Good reputation is likely to encourage patient confidence, break the barrier of fear and anxiety and improve the dynamics of patient-doctor interaction. This enhances self-control and patient empowerment, increases pain tolerance, ensures quicker recovery and a shorter hospital stay.[10,11] It encourages patients to open up about their illness facilitating rapid and accurate diagnosis and may enhance patient compliance and treatment outcome.[12]

"*I think the reason reputation is important because people might not go to their GP or dentist to get referred. If there is a problem they might put things off and off until it gets really bad to avoid coming if they've heard something*."

Relational coordination

A multidisciplinary evidence-based approach to patient care in OMFS in the UK is now seen a pre-requisite for effective patient care. One of the important elements of professional reputation is co-ordination among different subgroups of the profession. Gittell *et al.*[13] showed the more co-ordination among different teams of an organisation, the better their reputation. Coordination has been shown to improve both quality of care and performance.[13]

Several of the interviewed patients strongly believed that coordination of healthcare services influenced their perception of quality of care and reputation of the profession. In OMFS, coordination between administrative, medical, management, and nursing

groups is crucial to deliver an efficient service, better patient satisfaction, create a positive environment, and increase productivity.

"*I would say quality of staff, sufficient numbers of staff as well. You haven't got just one or two doctors that are fantastic you want the whole support, the facilities, the surgeons, the doctors, the nurses, after-care is exceptionally important. The outpatients department, appointments sorted out, what is the aftercare like? I know in a lot of departments as soon as your major problem is fixed they're not interested. I think that is the most important as well.*"

Despite the importance of relational coordination in professional reputation, the NHS was seen as lacking in this key respect by patients.

Social responsibility

Social responsibility refers to actions and policies adopted by an organisation to further some social good beyond its direct interests and is required by law.[14] The greater social responsibility an organisation shows, the more favourably it is perceived by stakeholders.[15]

In broad terms, medical organisations are expected by society to respond sensitively to health-related challenges that arise as a result of political, social or cultural changes within society. The participants of this study were unable to agree on the definition or limits of social responsibility of OMFS. A few went as far as suggesting that doctors should be actively involved in health-related matters in schools, police stations and the community. The vast majority believed that 'a hands on approach' is impossible due to time limitation and clinical responsibilities.

"*It's a very time-consuming job that you do, I mean you would be spreading yourself very thinly.*"

The role of the media and the Internet

Interviewees suggested that that the media and the Internet had a powerful impact on reputation of the profession. Wide availability and easy accessibility make them the perfect medium to bad publicity or poor quality information.[16,17] According to participants, the medical profession had no choice but to accept this reality and to develop strategies to deal the challenges it brings. They suggested actively monitoring related published material and active engagement in reputational management.

Patients wanted more information about their illness and the treatments they receive. Information enhances the transparency of patient-doctor interaction and promotes the 'feel good sense' with subsequent impact on professional reputation.

"*The thing about newspapers is that bad news sells papers and people are more inclined to go out of their way to complain about bad service than they are to say what a fantastic experience they have. People have a tendency to complain as opposed to praise.*"

Discussion

This study shows that the reputation of OMFS is undermined by naming inconsistencies, perception-reality gap and regulatory paradox. The more consistent the message of an organisation, the more likely people are to believe in it and support it.[18] Agreement on a single consistent name would create a strong reputation construct for OMFS and a clear identity among other competing surgical specialties. Organisational consistency plays a vital role in shaping reputation and 'social alignment'.

OMFS in the UK may suffer some survival challenges due to public fund cuts in the current economic climate, which may revive the question of the economic viability of a perceived lengthy and cost-inefficient training. These dynamic changes alongside a stakeholders' shift may make the reputation-reality gap more profound and increase risk to professional reputation.[19]

These internal (e.g. inconsistency issues, regulatory status) and external challenges (e.g. political landscape and economic changes) make the subject of OMFS reputation increasingly important. The profession must develop reputational management strategies. Organisational reputation is the cumulative product resulting from the interaction between stakeholder perception (external view) of an organisation and the organisation assets reflected by its employees (internal view). The alignment between internal and external influences is the main focus of organisational reputation management. The BAOMS and OMFS departments, the NHS, academics, patients, trainees should steer an action group to address these issues by implementing a clear reputation strategy.

Reputational and leadership initiatives such as cultural change, openness, active feedback, strong relational coordination, clear social responsibility, an efficient training pathway and improving media visibility should be considered.

Reputation is a subjective social phenomenon due to its reliance on stakeholders' perceptions, which changes over time, and according to experience as well as socio-economic, political and cultural developments.[9] The more the values and practices of the profession aligns with stakeholders' perceptions the more legitimate the profession, the more positive its reputation, and the greater its reputational reserve.

One of the interesting findings of this study is the perception-practices gap[19] in that patients perception of a dental qualification as part of OMFS training is disadvantageous, and contrary to the professional view, seems to undermine professional reputation. The perception-practice gap might be narrowed with increased transparency, the provision of greater information, and effective feedback.

We propose two potential strategies to manage reputation. 'Preventive or 'pre-emptive' strategies whereby OMFS should take active steps to reduce the risk of reputational damage. Launching publicity campaigns (articles in newspapers, TV adverts, online blogs, school visits, community centres), inviting patients/public to appropriate departmental and professional meetings, media coverage of annual

conferences and professional events, a dedicated team for managing professional reputation, and directing patients to trusted websites including individual OMFS unit websites would increase awareness.[20]

The other is a 'reactive strategy' to deal with reputational and public relationship problems when they arise. This is perhaps the commonest strategy currently adopted by medical organisations. A realistic model is a combination of both preventive and reactive strategies running in parallel that forecast upcoming political and social changes and align the organisation in preparation for them, but also react objectively to reputational risks.

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Conflict of interest

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