



Patients' Perception of the 'Rough' Dentist During Routine Dental Procedures: A Narrative Review

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ABSTRACT :

Background: Patients often describe a dentist as “rough” even when routine procedures such as local anaesthesia, scaling, restorations and extractions are performed to an accepted standard. This perception influences satisfaction, trust, attendance and the development of dental fear, yet it is rarely defined or examined as a construct in its own right.

Objective: To synthesise the available literature on why patients perceive routine dental treatment, and the dentist delivering it, as rough, and to identify modifiable clinician, patient and environmental factors.

Methods: A narrative review was conducted. Literature on dental pain, dental anxiety, dentist–patient communication, trust and patient-centred care was identified through targeted searches of biomedical databases and reference lists, and interpreted thematically.

Findings: Perceived roughness appears to arise from the interaction of six domains: anticipated and actual pain, dental anxiety and prior experience, unpleasant sensory and tactile stimuli, limited communication and sense of control, embarrassment and vulnerability, and loss of trust. Pain and anxiety are strongly and reciprocally related, and patients' judgments of a dentist's gentleness are shaped as much by interpersonal behaviour as by technical handling. Evidence specific to the label “rough” is limited, and most studies address dental anxiety or satisfaction rather than the perception itself.

Conclusion: Perceived roughness is a patient-experienced outcome that is only partly explained by technique. Gentle tissue handling, careful anaesthetic delivery, explanation before and during treatment, shared control signals and attention to anxiety may reduce it. Validated measures and primary studies of this construct are needed.

Keywords: dentist–patient relationship; dental anxiety; patient perception; dental pain; patient-centred care; communication

1. Introduction

Few words damage the dentist–patient relationship as quickly as “rough”. Patients use it to describe a dentist whose hands, instruments or manner they experienced as heavy, hurried or careless, whether or not the treatment was technically appropriate. The perception matters because it shapes whether patients return, whether they trust the clinician and whether they refer others.

Dental fear is common. A systematic review and meta-analysis estimated its pooled prevalence in adults at roughly 15% [1]. Fear and anxiety lead to avoidance, delayed care and worse oral health, which in turn make later treatment more complex and more frightening, a pattern described as the vicious cycle of dental fear [2,3]. Pain is defined as an unpleasant sensory and emotional experience [4]. A patient's judgment that treatment was rough is therefore never purely mechanical: it combines what was physically done with what the patient expected, felt and understood.

Early clinical studies already identified the dentist's behaviour and previous painful experiences among the reported causes of dental fear [5], and the psychosocial consequences of fear are well documented [6]. Patient-centred care, which attends to communication, shared decision-making and the patient's perspective, is increasingly recognised as a core component of quality in general dental practice [7]. Despite this, the term “rough” is seldom defined in the literature. It sits at the intersection of pain, anxiety, communication and trust, and it is usually studied indirectly through satisfaction or anxiety scales.

A dentist can perform a standard procedure correctly and still be perceived as rough. Understanding why is clinically important, because many of the

contributing factors are modifiable. This gap in the literature is the rationale for the present review.

Objective: To synthesise the existing literature on how patients perceive roughness during normal dental procedures, to identify the factors that shape that perception, and to outline practical implications for clinicians.

2. Materials and Methods

Study design. This is a narrative review, chosen because the construct under study is poorly defined and spans several research traditions, which makes a systematic review of a single outcome impractical. The approach followed published guidance for narrative reviews [8], and the manuscript was structured with reference to the SANRA quality criteria [9].

Literature sources and search approach. Literature was identified through targeted searches of PubMed/MEDLINE, Scopus and Google Scholar, supplemented by hand-searching the reference lists of key articles. Search terms combined concepts such as dentist, patient perception, rough, gentle, dental anxiety, dental fear, dental pain, injection pain, communication, trust, patient-centred care and satisfaction. [Author to confirm and insert the actual databases, search dates and date range before submission.]

Eligibility. Peer-reviewed articles in English addressing adult or paediatric dental patients and the experiences, behaviours or factors linked to pain, anxiety, communication, trust or perceived quality of care during routine procedures (local anaesthesia, restorative treatment, scaling and extractions) were considered. Case reports, purely technical studies without patient-reported outcomes and non-peer-reviewed commentary were excluded, apart from standard textbooks used for clinical background.

Synthesis. Findings were grouped thematically. Because the literature is heterogeneous and rarely measures “roughness” directly, no meta-analysis or formal risk-of-bias scoring was attempted, and conclusions are presented as an interpretive synthesis rather than pooled estimates.

Ethical considerations. This review used published literature only and involved no human participants or patient data. Ethical approval and informed consent were therefore not required.

3. Results and Discussion

The literature does not treat roughness as a defined outcome. Across the included work, six interacting domains explain why patients describe routine treatment, and the dentist providing it, as rough. These domains overlap, and a single appointment often involves several at once.

3.1 Anticipated and actual pain

Pain is the most direct driver. A systematic review and meta-analysis found a positive association between anxiety and pain during dental treatment [10], so an anxious patient is likely to experience and report more pain from the same procedure. Memory amplifies this: patients’ recollections of dental pain are shaped by their expectations and fear, and can differ from the pain reported at the time [11]. Pain catastrophising, the tendency to magnify and ruminate on pain, is a measurable trait that further inflates perceived intensity [12].

Injection technique is a recurrent flashpoint, because the needle is often the first and most feared step. Slower, lower-pressure delivery of local anaesthetic has been associated with less pain and anxiety [13], and standard texts describe topical anaesthesia, careful tissue handling and slow injection as basic principles of comfortable anaesthesia [14]. A patient who feels a sudden, forceful injection is likely to label the clinician rough, even if the anaesthetic is fully effective.

3.2 Dental anxiety and prior experience

Dental anxiety frequently begins early in life [15], and a previous painful or insensitive encounter conditions how later treatment is read. Validated instruments such as the Dental Anxiety Scale [16] and the Modified Dental Anxiety Scale [17] allow clinicians to identify anxious patients before treatment, and guidance on measuring anxiety and pain in dentistry is available [18]. An anxious patient interprets neutral sensations, such as pressure, vibration or retraction, as threatening. The same hand movement may therefore be experienced as gentle by one patient and rough by another, which is why technique alone cannot explain the perception.

3.3 Sensory and tactile stimuli

Routine treatment contains stimuli that are unpleasant without being painful: high-speed handpiece noise and vibration, water and aerosol, taste, prolonged

mouth opening, pressure from retractors, mouth props and rubber dam clamps, and a supine position that limits swallowing and breathing comfort. These stimuli are widely recognised triggers in the anxiety literature and are addressed in practical management strategies [19]. When they are unexplained or prolonged, patients tend to attribute them to the dentist's handling rather than to the procedure. Forceful retraction, abrupt instrument movement, working without pauses and leaving a patient in an uncomfortable posture are behaviours most likely to be read as roughness.

3.4 Communication, control and shared decision-making

Communication consistently emerges as a stronger determinant of how patients judge their care than technical factors alone. Reviews of doctor–patient communication link information-giving, empathy and partnership with satisfaction and compliance [20], and models of dentist–patient communication emphasise the two-way exchange of information and the patient's role in decisions [21]. Patient-centred dental care is associated with better patient experience [7]. A person-centred communication approach is also related to lower dental anxiety and better attendance behaviours [22].

Perceived control is central. A patient who has been told what will happen, who knows when it will start, and who has an agreed stop signal is less likely to experience treatment as something done to them. Conversely, silence, rapid commentary directed to the assistant, or a clinician who continues after a patient signals discomfort conveys a lack of care, even when the movements are gentle.

3.5 Embarrassment, vulnerability and power asymmetry

The dental chair places the patient in a vulnerable position: lying back, mouth open, unable to speak, and exposed to judgement about oral hygiene. Qualitative work shows that embarrassment contributes to phobic dental anxiety and to avoidance [23]. A patient who feels judged or rushed may describe the dentist as rough in tone as well as in touch. A critical remark about neglect, delivered mid-procedure, can leave the same impression as a physical rough movement.

3.6 Trust

Trust in a clinician is built on perceived competence, caring and honesty, and it influences how patients interpret ambiguous experiences [24]. Where trust is high, discomfort is more likely to be attributed to the procedure; where it is low, the same discomfort is attributed to the dentist. Trust is therefore both a protective factor against the perception of roughness and an outcome that roughness damages.

3.7 Practical implications for clinicians

Because the contributing factors are largely modifiable, clinicians can reduce perceived roughness through measures supported by the anxiety-management and communication literature [2,19,25,26]. Table 1 summarises how patient-reported complaints map onto likely drivers and responses. It is an interpretive synthesis, not a set of tested interventions.

Table 1. Patient descriptions of roughness, likely drivers and possible clinician responses.

What the patient may describe	Likely driver	Possible clinician response
"The injection was brutal"	Injection pain and anticipation	Topical anaesthetic, slow low-pressure delivery, warn before the needle [13,14]
"He pulled and pushed my mouth"	Retraction, mouth prop and tissue handling	Gentle retraction, planned breaks, support the jaw
"Nobody told me what was happening"	Low information and low control	Explain each step, agree a stop signal [20,21]
"He was in a hurry"	Pace and perceived disinterest	Pause, check in, allow questions [7,22]
"He made me feel bad about my teeth"	Embarrassment	Non-judgemental language, discuss findings upright [23]
"I don't want to go back"	Lost trust and rising anxiety	Acknowledge the experience, screen for anxiety, rebuild rapport [17,24]

For patients with established anxiety, psychological approaches such as cognitive behavioural therapy have the strongest evidence of benefit [26], and clinical management of dental anxiety should be matched to the individual patient [25]. In children, fear is associated with child, parent and previous-

experience factors [27], which makes calm, explained care in the first visits especially important.

There is also an ethical dimension. Respect for patient autonomy, beneficence and non-maleficence require clinicians to take a patient's report of being hurt or mishandled seriously, rather than dismiss it as oversensitivity [28]. At the same time, a perception of roughness is not proof of poor technique, and clinicians should avoid defensive responses that further damage trust.

3.8 Limitations of the evidence and of this review

No validated instrument measures perceived roughness directly, and most evidence is drawn from studies of dental anxiety or satisfaction. Studies vary in population, setting and measurement, and many are cross-sectional, which limits causal inference. The review is narrative, not systematic, and may be affected by selection bias. Little evidence addresses the South African private-practice context or cultural variation in how roughness is understood and expressed. Future work should develop and validate a patient-reported measure of perceived gentleness, combine qualitative interviews with observation of clinician behaviour, and test communication and technique interventions.

4. Conclusion

Perceived roughness during routine dental procedures is a patient-experienced outcome that technique alone does not explain. It emerges from the interaction of pain, anxiety, unpleasant sensory stimuli, communication and control, embarrassment and trust. Because most of these are modifiable, clinicians can reduce the perception through gentle tissue handling, careful anaesthetic delivery, explanation before and during treatment, agreed stop signals, non-judgemental language and early attention to anxiety. The evidence is indirect, and validated measures and primary studies of perceived roughness are needed before firm recommendations can be made.

Acknowledgements

The author has no individuals or institutions to acknowledge.

Funding Statement

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Conflict of Interest

The author declares no conflict of interest.

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