# Patient-Generated Aspects in Oral Rehabilitation Decision Making. II. Comparison of an Individual Systematic Interview Method and the Oral Health Impact Profile

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***Purpose:*** The effect of impaired oral functions is best described by the patient, and a shift toward a patient-oriented decision-making process in oral rehabilitation is evident. The Oral Health Impact Profile-49 (OHIP-49) questionnaire has been the most commonly used method to measure oral health–related quality of life (OHRQoL) in dentistry. An individualized method, the Schedule for the Evaluation of Individual Quality of Life–Direct Weighing (SEIQoL-DW), has proven to fulfill most of the criteria for a method to assist in the decision-making process. The purpose of this study was to compare the ability of the OHIP-49 questionnaire and the SEIQoL-DW method in measuring OHRQoL and generating useful information for decision making in oral rehabilitation. ***Materials and Methods:*** Sixty participants in need of oral rehabilitation were enrolled in the study. Patients received a clinical examination, were interviewed using the SEIQoL-DW, filled out the OHIP-49 questionnaire, and answered two global oral health–rating questions. ***Results:*** The SEIQoL-DW generated additional information compared to the OHIP-49. The information was more oral- and treatment-specific, including consultation issues and the patient-practitioner relationship. The overall SEIQoL-DW and OHIP-49 scores were significantly correlated. The OHIP-49 and SEIQoL-DW scores were related to oral health subjectively. ***Conclusions:*** The SEIQoL-DW method proved a useful aid in clinical decision making for oral rehabilitation. The SEIQoL-DW was more appropriate for generating information useful for decision making than measuring OHRQoL; the OHIP-49 was more appropriate for measuring OHRQoL than generating information. *Int J Prosthodont 2010;23:421–428.*

The treatment modalities in oral rehabilitation are numerous. When to treat and which treatment to choose has historically been decided by the clinician, often in an unstructured manner that is considered more art than science.[1–4] A shift from this "paternalistic" attitude toward a more patient-oriented one has become evident,[5] in line with shared decision making.[3] The importance of patient involvement in clinical decision making has been outlined,[6–8] which has given rise to a number of methods for measuring the patient's thoughts and needs in dentistry.[9] These methods have come to be known as measures of oral health–related quality of life (OHRQoL).[10] The measures have mostly been used in population studies and not for individual clinical treatment planning.[11] It has been stated, however, that the OHRQoL measures could potentially be used to predict treatment needs and select therapies.[9,11]

By using methods to incorporate patient-generated aspects of treatment, the practitioner is thought to be able to prescribe a better individualized treatment plan.[8,12,13] It has been emphasized, however, that such methods are not substitutes for objective measures, but rather an adjunct.[6,9] In clinical practice, a measure to aid in the decision-making process should be a simple and structured one.[6] It should fulfill the practitioners need for information, and the information generated should be exhaustive.[14]

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The best validated OHRQoL measure is the Oral Health Impact Profile-49 (OHIP-49) questionnaire.[15] This measure has been used to describe OHRQoL in different populations, including patients with tooth loss and removable dentures,[16] conventional and implant-retained dentures,[17] and elderly patients.[11] Questionnaires such as the OHIP-49 offer the clinician a quick and easy-to-use method to obtain information from the patient. However, they consist of predefined standardized questions,[18] which may potentially neglect the problems, needs, or wishes of the individual patient when not contained in the questionnaire.[6] Instead, individualized measures have been suggested as means of obtaining more accurate information from patients.[6] To be able to capture the complexity of a problem, impacts of the treatment on the patient should not only be recognized but also quantified.[7] The OHIP-49 measures the frequency of impact but fails to quantify the meaning and importance of the problem.[18]

An interview measure designed to generate information at an individual level has been introduced in medicinal OHRQoL research. The Schedule for the Evaluation of Individual Quality of Life–Direct Weighing (SEIQoL-DW)[19] has been used both as a measure of quality of life and as a method for generating information on specific populations. The method has been used to measure quality of life in patients with amyotrophic lateral sclerosis[20] and to describe the troubles of older patients.[21] Moons et al[22] stated that the SEIQoL-DW proved to be a valid measure to determine quality of life. In dentistry, it has been used as a measure of quality of life in edentulous patients[23] and as a tool for generating information related to decision making, as well as measuring OHRQoL in patients with tooth loss and removable partial dentures.[24] Özhayat et al[24] found that the SEIQoL-DW could provide a deeper understanding of the patient's needs and wishes. They evaluated the method as a useful tool to aid in decision making and treatment planning in dentistry.

Since the OHIP-49 is a well-established method to evaluate OHRQoL and the SEIQoL-DW is a new measure of OHRQoL, it seems highly relevant to compare the two. The purpose of this study was to compare the ability of the OHIP-49 and the SEIQoL-DW in measuring OHRQoL and generating useful information for decision making in oral rehabilitation.

## Materials and Methods

This study was approved by the Danish Data Protection Agency. Participants were selected from patients at the School of Dentistry, University of Copenhagen, Copenhagen, Denmark. Sixty patients seeking treatment at the clinic for undergraduate students were selected. The following inclusion criteria were used: no pain, diagnosed in the traditional way to be in need of replacement of at least one missing tooth at the screening visit, and capable of conversation in Danish. The 60 participants consisted of 30 women and 30 men. The median age was 60 years (range: 32 to 77 years). Demographic descriptions of the participants are available elsewhere.[25]

### *Study Design*

Before a participant was subjected to the two methods, a clinical examination was performed. At another visit, before any oral treatment, participants were interviewed using the SEIQoL-DW method and filled out the OHIP-49 questionnaire in a randomized order. The interviews were audio taped, and the time spent was recorded in minutes for both methods. Then, two global rating questions were answered.

From the clinical examination, data were obtained regarding the number of teeth, tooth spaces (anterior/posterior), and removable dental prostheses (RDPs). Number of teeth included natural teeth and pontics used for fixed dental prostheses. None of the participants had implant-retained replacements or complete dentures. A tooth space was recorded as anterior if the edentulous area was between or including the canines.[26] If the participant was wearing an RDP, tooth-space recording was done with the prosthesis in situ.

### *SEIQoL-DW*

The SEIQoL-DW interview method consisted of four steps (Table 1).[19,24,25] From a qualitative interview, cues from the individual participant were provided. All cues mentioned by the participant, called SEIQoL-DW cues, were noted. Afterward, the participant nominated the 5 most important cues, referred to as nominated SEIQoL-DW cues. The total number of nominated SEIQoL-DW cues was 300, since the 60 participants each nominated 5 cues. Participants rated the actual status, using a visual analog scale, and importance, using the direct weighing instrument, of each nominated cue. From the status and importance ratings, an overall score was calculated (SEIQoL-DW score).

### *OHIP-49*

The OHIP-49 contains 49 questions related to problems encountered in the oral region.[15] Participants answered how often each problem had occurred during the past month on a scale with six choices and respective scores: very often (4), fairly often (3), occasionally (2), hardly ever (1), never (0), or don't know (0). To calculate an overall OHIP-49 score for each patient, the scores from the 49 answers were added, thereby producing an overall score between 0 and 196. OHIP-49 cues were


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chosen as questions whose answers scored between 1 and 4. These were used for comparison with the SEIQoL-DW cues and nominated SEIQoL-DW cues.

### *Global Rating of Oral Health*

The Global Rating of Oral Health consists of two questions[27] (GROH1 and GROH2): *(1)* Would you say that the health of your teeth, lips, jaws, and mouth is …? and *(2)* How much does the condition of your teeth, lips, jaws, or mouth affect your life overall? The first question was answered by marking one of the following: very poor, poor, okay, good, or excellent. The second was answered by marking one of the following: very much, some, occasionally, rarely, or not at all. The answers were given scores from 1 to 5, with 1 being the poorest health or the most affection.

### *Quantitative Differences Between SEIQoL-DW and OHIP-49 Cues*

A cue was considered a word, opinion, description, or a sense expressed by the participant. For each participant, cues from the two methods were compared. The differences between cues from the methods were focused on rather than the similarities, making it possible to highlight contrasts between the methods and thereby evaluate the different abilities of each method to generate information to be used in the decision-making process. Cues from the SEIQoL-DW interview not identified in the OHIP-49 were therefore noted and counted and vice versa.

### *Qualitative Differences Between SEIQoL-DW and OHIP-49 Cues*

Only nominated SEIQoL-DW cues were used to represent the information from the SEIQoL-DW in the qualitative analysis. Cues with the same wording were pooled initially. The types of cues mentioned in the SEIQoL-DW interviews but not mentioned in the OHIP-49 and vice versa were noted as indicators of the qualitative difference between the two methods. The difference in cues recorded from the methods was used to establish and compare more general themes of the patients' thoughts on their own oral situation.

### *Reliability of Registrations*

All SEIQoL-DW interviews, as well as all extractions from the OHIP-49, were performed by one examiner. Both were tested for reliability.

For the evaluation of the SEIQoL-DW interview, 12 randomly selected interviews were analyzed by a separate examiner skilled in the interviewing technique.

**Table 1** Steps in the SEIQoL-DW Method

| | |
|---|---|
| **1.** | Generation of cues by a qualitative interview and nomination of the five most important cues. |
| **2.** | Rating of the actual status of the five chosen cues on a visual analog scale. |
| **3.** | Evaluation of the relative importance of the five cues using the DW instrument. |
| **4.** | Calculation of a score for each cue and an overall SEIQoL-DW score for each patient. |

That examiner listened to the audio-recorded interviews and made notes on the participants' statements. Afterwards, the notes were compared with the analysis performed by the first examiner to identify differences in the noting of cues. The examiner's behavior was also evaluated. This was done by recording whether the participants were allowed to express their opinions without being guided by the examiner.

To evaluate the comparisons between the OHIP-49 and SEIQoL-DW, another examiner went over 15 randomly chosen OHIP-49 questionnaires. The same procedures were used to extract cues from the OHIP-49 and to compare the SEIQoL-DW and OHIP-49.

### *Statistical Analysis*

SAS statistical software (version 9.1, SAS Institute) was used for all calculations. The level of significance was set at $P < .05$.

The reliability of the records was calculated by means of measures of agreement and the chi-square test. The measures of agreement consisted of a formula for calculating the maximum coefficient of variation (CV) in the number of cues between examiners. The formula used the standard deviation of the differences in the number of cues ($SD_{diff}$) divided by the mean number of cues:

$$CV = (SD_{diff} / \text{mean}) \times 100\%$$

Descriptive statistics were used to compare the number of cues from the two methods. The Student *t* test was used to locate differences in the number of cues between the methods. To compare the overall SEIQoL-DW and OHIP-49 scores, a scatter plot was constructed. A linear model was used to test the parameters of the regression line, and the scores were correlated. For comparison of the connection between the GROH scores and the overall SEIQoL-DW and OHIP-49 scores, plots were constructed and analysis of variance was used to find significant differences.

A regression analysis based on a Poisson distribution was completed to investigate the impact of number of teeth, anterior tooth spaces, and RDPs on the



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**Table 2** Median No. (Range) of SEIQoL-DW and OHIP-49 Cues and No. of Cues Missing when Compared

| Method | Median no. of cues per participant |
|---|---|
| SEIQoL-DW | 17 (11–29) |
| OHIP-49 | 20 (1–47)* |
| Missing in OHIP-49 | 11 (3–17)* |
| Missing in SEIQoL-DW | 3 (0–11) |

*Significant difference.

**Table 3** Nominated SEIQoL-DW Cues Not Found in the OHIP-49 and OHIP-49 Cues Not Nominated in the SEIQoL-DW

| Cues not in OHIP-49 | Cues not in SEIQoL-DW |
|---|---|
| Keep own teeth | Sensitive teeth (Q12) |
| Natural teeth | Tensed (Q23) |
| Clean teeth | Sleep disturbance (Q33) |
| Information | Lack of concentration (Q37) |
| Regular check | Irritable (Q42) |
| Trust in dentist | General health worsened (Q44) |
| Confidence in treatment | Unable to work (Q49) |
| Attentive dentist | |
| No time pressure in consultation | |
| Fear of the dentist | |
| Lack of consideration | |
| Economics | |
| FDP/not RDP | |
| Lasting solution | |
| Cavities | |
| Periodontitis | |
| Mobile teeth | |
| Worn teeth | |
| Fractured teeth | |
| Dry mouth | |
| Intact teeth | |
| Deep bite | |
| Sharp tooth | |
| Lack of bone | |
| Lack of teeth | |
| Food hits the gum | |
| Untidy feeling | |
| Feeling of intact mouth | |
| Upper lip too far in | |
| Composite falls off front teeth | |

number of cues from the two methods. To test the influence of number of teeth, anterior tooth spaces, and RDPs on the overall SEIQoL-DW and OHIP-49 scores, a regression analysis was performed based on a normal distribution. Kolmogorov-Smirnov goodness-of-fit tests, histograms, and probability plots showed that the score had a normal distribution.

## Results

The median number of teeth was 23 (range: 7 to 31). All subjects had posterior tooth spaces and 30 (50%) had additional anterior tooth spaces. There were 13 participants wearing RDPs (22%). No participant had more than one RDP.

### *Reliability of Registrations*

The reliability tests showed: *(1)* When comparing the examiners' notes, no significant difference was found in the evaluation and noting of information from the interviews. The noting of cues from the interviews was thus considered satisfactory. One examiner concluded that the participants were allowed to express their opinions without being guided by the examiner. *(2)* Comparison in number of cues from the OHIP-49 identical to the interview showed a CV of 42.5% and no significant systematic difference ($P = .25$). Comparison in number of cues from the SEIQoL-DW to the OHIP-49 showed a CV of 20% and no significant systematic difference ($P = .88$).

### *Quantitative Differences Between SEIQoL-DW and OHIP-49 Cues*

**Total.** The total number of cues generated by the 60 participants in the SEIQoL-DW was 1,077; the OHIP-49 generated 1,351. There was no difference in the number of cues generated in relation to sex. The median number of cues generated from the SEIQoL-DW interviews and the OHIP-49 and the median number of cues missing in each method when compared to the other are shown in Table 2. There was a significant difference between the number of cues from the two methods ($P = .009$). When the cues were compared, 3 of 20 cues (15%) from the OHIP-49 were missing in the SEIQoL-DW interviews, and 11 of 17 cues (65%) from the SEIQoL-DW interviews were missing in the OHIP-49. This difference was significant ($P < .001$).

**Teeth, Anterior Spaces, and RDPs.** The results from the linear model investigating the relationship between the number of cues generated by the two methods and the variables number of teeth, anterior tooth spaces, and RDPs showed no significant influence on the number of cues generated.

### *Qualitative Differences Between SEIQoL-DW and OHIP-49 Cues*

When the 300 nominated SEIQoL-DW cues were analyzed, 58 different cues were identified. The 1,351 OHIP-49 cues covered all 49 items in the questionnaire. The cues from the SEIQoL-DW not recorded in the OHIP-49 and the cues from the OHIP-49 not mentioned in the SEIQoL-DW are listed in Table 3.

Cues nominated in the SEIQoL-DW and not repeated in the OHIP-49 were gathered into three categories: *(1)* consultation situation and the role of the clinician, including the cues information, regular check, trust in dentist, no time pressure in consultation, confidence in treatment, attentive dentist, lack of consideration, and fear of the dentist; *(2)* patients' wishes, expectations,


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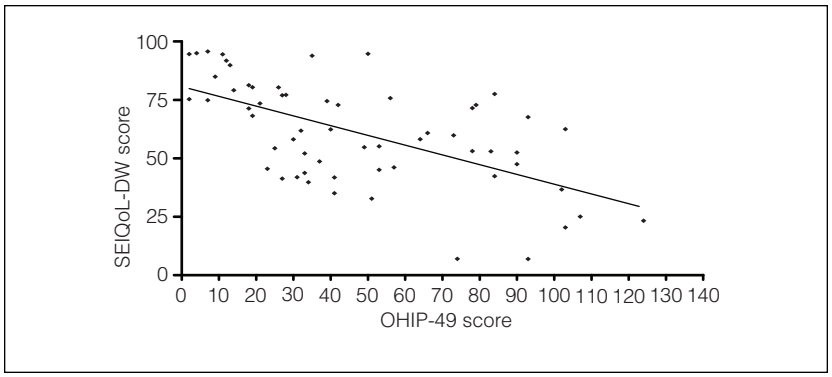
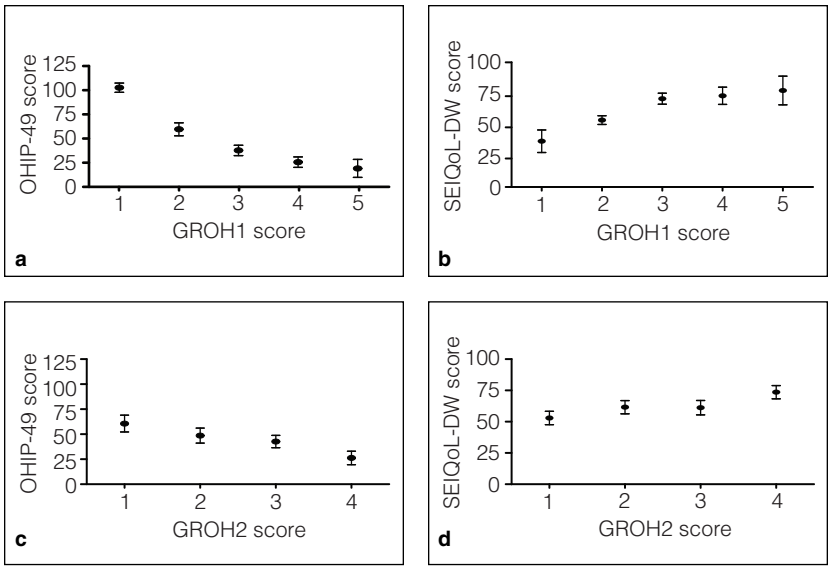



**Fig 1** Scatter plot of the relationship between the overall OHIP-49 and SEIQoL-DW scores.




**Figs 2a to 2d** Plot of the relationship between the answers to the global oral rating questions (GROH1 and GROH2) and the OHIP-49 and SEIQoL-DW scores.

and alternatives for treatment, including the cues keep own teeth, economics, FDP/not RDP, natural teeth, and lasting solution; and *(3)* physical problems with teeth and oral cavity experienced by the participant, including the cues cavities, periodontitis, mobile teeth, worn teeth, fractured teeth, and dry mouth.

The OHIP-49 cues not repeated in the SEIQoL-DW revealed a theme of general affection of oral problems, with the cues sleep disturbance, lack of concentration, irritable, general health worsened, and unable to work.

### *Overall OHIP-49 and SEIQoL-DW Scores*

The mean OHIP-49 and SEIQoL-DW scores were 47.28 and 60.92, respectively. There was no difference in relation to sex in either overall OHIP-49 or SEIQoL-DW score.

The SEIQoL-DW score for each patient was plotted against the OHIP-49 scores (Fig 1). The linear model showed a β-coefficient of –0.42, with a standard error of 0.07. The two scores were significantly correlated ($P < .001$).

The results from the linear model investigating the relationship between the SEIQoL-DW and OHIP-49 scores and the variables number of teeth, anterior tooth spaces, and RDP showed no significant influence on any of the overall scores.

### *GROH*

The association between the overall SEIQoL-DW and OHIP-49 scores with the GROH score categories is shown in Figs 2a to 2d.

Analysis of variance showed a significant difference between the GROH1 groups for the OHIP-49 score (Fig 2a, $P < .0001$), as well as the SEIQoL-DW score (Fig 2b, $P = .0004$). The tests showed a significant difference between the GROH2 groups for the OHIP-49 score (Fig 2c, $P = .05$) but not with the SEIQoL-DW score (Fig 2d, $P = .13$).



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### *Time*

The average time the participant spent on the SEIQoL-DW method was 23 minutes, with a range of 13 to 42 minutes. For the OHIP-49 questionnaire, 9.7 minutes was the mean, with a range of 4 to 28 minutes.

## Discussion

The results showed that the SEIQoL-DW method generated more differentiated information compared to the OHIP-49 questionnaire. The additional information concerned consultation issues, the patient-practitioner relationship, treatment preferences, and oral-specific cues. The overall scores of the two methods were correlated significantly and showed a relationship to patient-reported oral health.

The traditional clinical measures are characterized as "hard" because they are reasonably objective, accurate, and reproducible. Self-reported measures are considered "soft" and more unreliable because they are subjective, do not necessarily correlate with clinical measures, and emanate from the patients.[28] Just because a measure is soft, however, does not mean that it is less important in the decision-making process. By using a patient-centered method to generate information, the patient feels more involved in the process, and a better patient-practitioner relationship can be established. It has been shown that if the patient is more involved in the decision-making process, there are fewer tendencies toward complications, dissatisfaction, and complaints.[12] OHRQoL measures could be used to involve patient-generated aspects in clinical decision making.[6,9,28] In decision making for oral rehabilitation, where the disparity in treatment options is great, individualized techniques for generating relevant patient aspects have, however, recently been introduced.[24,25]

It has been argued that 10 to 50 interviews are sufficient to describe qualitative phenomenons in descriptive studies.[29] When a comparison of methods with quantitative data is to be made, a sample size of at least 50 participants has been recommended.[30] In the present study, both qualitative and quantitative analyses were performed regarding 60 participants. This size of the sample made it difficult to find significant differences. The number of participants was, however, sufficient to describe differences between the methods, and the intraindividual crossover study design strengthened the results of the study. A generalization of the results must be made with caution, however, since the population in this study included only patients attending the dental school.

The SEIQoL-DW is based on a qualitative interview, which by definition is a product of both the participant and the interviewer.[31] To minimize the bias, all interviews were carried out by the same interviewer. Even though interrater reliability is of limited concern for validation of a quality of life instrument,[32] the reliability of registrations from the SEIQoL-DW and OHIP-49 was investigated. No systematic difference was found between the examiners and the reliability was considered acceptable.

A large amount of information does not necessarily give a complete picture of the patient's problems, wishes, and expectations, but it helps to reveal hidden problems and facilitates clinical decision making.[6] If the clinician incorporates the patient's perspective into the treatment plan, a greater chance of achieving at least subjective treatment success can be expected.[12] The results in the present study showed that the SEIQoL-DW generated a smaller amount of cues than the OHIP-49. However, the SEIQoL-DW generated cues that matched the OHIP-49, as well as additional aspects. Cues regarding the consultation/treatment process, expectations and wishes for treatment, and relationship with the clinician were not included in the OHIP-49 questionnaire, even though they have proven to be of great importance.[12] Cues regarding these topics were mentioned repeatedly during the SEIQoL-DW interviews, which supports the claim that they are highly relevant patient concerns.

The extent to which the patient-provider relationship influences decision making is not yet fully understood. The physician-patient working alliance was found to be important and associated with patient adherence and satisfaction when a group of patients with chronic medical illnesses were investigated.[33] In dentistry, Oates et al[34] investigated factors of importance to likelihood of treatment in patients with high dental reconstructive needs and found that the factor of greatest influence was the patient-provider relationship. In an international multicenter study, it was found that of 38 topics, time, information, confidentiality, and trust were within the top 5 patient priorities in general practice.[35] This also supports the claim that the SEIQoL-DW method identifies important aspects needed to be taken into account in clinical practice.

The two other themes extracted from the SEIQoL-DW that were not encompassed in the OHIP-49 regarded treatment wishes and oral-specific problems, which showed that the SEIQoL-DW captured relevant issues to be used in oral rehabilitation treatment planning. Since the OHIP-49 does not include items related to wishes and expectations, its applicability in decision making is limited.

The OHIP-49 score has been shown to be valid and reliable.[15,36] To test the ability of the SEIQoL-DW score to measure OHRQoL, the relationship between the two overall scores was tested. In the present study, the SEIQoL-DW and OHIP-49 scores were significantly


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correlated. The clinical indicators used in this study showed no influence on either of the overall scores. This only indicated that the SEIQoL-DW score was somewhat able to detect the level of OHRQoL. It does not, however, tell us which score is best.

To further compare the methods' potentials for measuring OHRQoL and to test the cross-sectional validity, global oral rating questions were used. The global ratings have been used in dentistry for comparisons of other methods previously.[11,37] When looking at the underlying construct of the methods, it could be suspected that the SEIQoL-DW score was not as prone to measure the global rating of oral health as the OHIP-49 score. Because of the open-ended questions, the SEIQoL-DW measure is based on highly individual aspects. Some of the cues nominated from the interviews—information, regular check, and no time pressure in particular—could be said not to influence oral health per se. The rating of these cues, however, does affect the SEIQoL-DW score and thereby affects the relationship between the score and global rating. The global rating of oral health was related to both the OHIP-49 and SEIQoL-DW scores in this study. This indicated that both OHIP-49 and SEIQoL-DW scores showed good cross-sectional validity and could be used as measures of patient-reported oral health. The subjective evaluation of the impact on life by the teeth and mouth was related to the OHIP-49 score but not the SEIQoL-DW. Again, this could be caused by the individual nature of the SEIQoL-DW and narrower construct of the OHIP-49. Together with the general health theme found in the OHIP-49, this suggested that the OHIP-49 score captured the overall impact of oral health on life more precisely than the SEIQoL-DW score. For the purpose of treatment planning in oral rehabilitation, the details of information gained, rather than the overall score, seem to be more useful. This has been said to be the case for both treatment indication and outcome evaluation.[18]

The OHIP-49 measures the impact of oral problems on life by recording how often certain oral problems occur. The frequency of occurrence in itself, however, does not tell how important the problem is to the patient. Locker and Allen stated: "While current measures assess the frequency with which these impacts occur, they fail to establish the meaning and significance of those impacts to the individuals who complete the questionnaires."[18] It has also been stated that the method of item reduction of the OHIP-49 left out what might have been important to some patients and that the OHIP-49, therefore, might not encompass all items important to the individual patient.[18]

The SEIQoL-DW seems to contain many of the qualities required of a method to be used as an aid in oral rehabilitation decision making. It provides patients the opportunity to nominate their own aspects and allows them to rate the severity and importance of others. This feature highlights the usefulness of the SEIQoL-DW method. The interview method also helps patients in clarifying their wishes and expectations. In earlier studies, 70% of participants stated that they gained new knowledge regarding their own oral situation when subjected to the SEIQoL-DW method.[24,25] Potential latent, subconscious, or unexpressed needs may thereby be illuminated.[38]

Higginson and Carr[6] described how quality of life measures can be used in a clinical setting. They stated that the measures could be used to prioritize problems, facilitate communication, screen for potential problems, identify preferences, and monitor changes or responses to treatment. They suggested the use of the measures "to identify individual problems and priorities for treatment and then negotiating treatment goals based on them."[6] Higginson and Carr also commented on individualized measures, such as the SEIQoL-DW: "They are designed to detect individuals' problems and as such are more readily interpreted in ways that are clinically meaningful. They also provide a basis for sharing clinical decision making between patients and clinicians, identifying patients' priorities for treatment, and facilitating the setting of realistic treatment goals."[6] In dentistry, a more unstructured way of incorporating patient-generated aspects into decision making has been used traditionally. By using a measure such as the SEIQoL-DW, more structure and more useful aspects can be expected to be at hand.[25]

The time any new form of interviewing takes in a clinical setting may be criticized and the cost-effectiveness questioned. One of the central aspects in oral rehabilitation is to find the correct treatment modality for the individual patient. McCaffery et al[39] stated that methods for aiding in decision making can make the process longer and more complex, but if the result is a better outcome, the method can be said to be successful.

Further development and application of the SEIQoL-DW method for practical use in clinical dental practice may be possible.

## Conclusions

This study indicated that the SEIQoL-DW method was more appropriate for generating information and fulfilling communication needs in oral rehabilitation than measuring OHRQoL. The OHIP-49 questionnaire was found to be more valid for measuring OHRQoL than generating information. The SEIQoL-DW method captured additional and more oral- and treatment-specific information than the OHIP-49 and indicated that the consultations and the relationship to the clinician are important for the patients seeking oral rehabilitation.



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