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Barriers to accessing dental care: dental health professional factors

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This article discusses the ways that the dental health professional can, sometimes unwittingly, discourage the patient from seeking dental treatment

Cohen[1] in her report on the FDI's classification of barriers to dental attendance stated that factors associated with the dental health professional had to be considered if dentist are to provide accessible dental health care for patients. The FDI stated that barriers in relation to the dental profession included:

> *...inappropriate manpower resources, uneven geographical distribution, training inappropriate to changing needs and demands and insufficient sensitivity to patient's attitudes and needs.*

If this category of barriers is to be applied to those working in general practice then they must be considered within the same category headings as for the patient (see part 7). For instance 'inappropriate manpower resources' and 'uneven geographical distribution' are commensurate with the patient category 'lack of access', 'training inappropriate to changing needs and demands' is equivalent to 'perception of needs', while 'insufficient sensitivity to patient's attitudes and needs', could be thought of as the influence of psycho-social factors such as occupational stress, time urgency and financial considerations with regard to the viability of the practice.

Case 1
John is 12 years old and has an uneasy working relationship with his dentist Ms A. She, on her part, responds badly to this anxious pre-adolescent, feeling that treating him is a waste of time and effort. She hates to see John's name in the appointment book and even at the prospect of treating him becomes irritable. John has, to quote Ms A, 'got under my skin'. She admitted that she has even thought that she could avoid treating him by being on leave when his next routine examination was due.

Ms A's responses to John (Case 1) provide an opportunity to examine how the FDI's classification of dental profession barriers can be applied to the general practice setting. There can be little doubt that Ms A in her relationship with John exhibits two if not three of the barriers to which Cohen[1] refers. The barriers constructed by Ms A could also be thought of as psycho-social influences with occupational stress, financial considerations, perceptions of John's needs and time urgency playing a role in Ms A's responses to provide accessible dental care for her pre-adolescent patient.

Thinking in this way permits an alternative view of barriers as a consequence of the dentist-patient interaction. It is proposed that since equivalent barriers exist for both patient and dentist, it is their interaction which reduces the dentist's ability to furnish accessible dental care and the patient's ability to access the service provided. It is the interaction and combination of dentist barriers with those of the patient that makes dental care inaccessible. If dentists are to assist people access routine care then they must be aware of their own role in limiting access and compliance.

Psycho-social factors

Occupational stress

The idea that dentistry is the most stressful of all of the health professions was first proposed by Cooper et al[2,3]. In the 1980s Cooper et al[2,3] proposed that occupational stress was due to:

> *...time-related pressures, fearful patients, high case loads, financial worries, problems with staff, equipment breakdowns, defective materials, poor working conditions and the routine and boring nature of the job.*

By the 1990s Humphris and Cooper[4] had identified four, new, additional stressors. These included concerns about the future of general practice dentistry, aggressive and hostile patients, worries about the risk of cross infection and fears about litigation. There could be little doubt that the dental profession was being repeatedly exposed to a variety of sources of occupational stress. For some the effects of occupational stress would be minimal and would be confined to feelings of concern about practice policy or worries about a particular patient. The case of Ms A and John is illustrative in this regard. For others occupational stress would have detrimental effects in that not only could these susceptible individuals suffer physical and/or emotional ill health (emotional exhaustion) but they could also experience a withdrawal of interest from their work (lowered personal achievement) and a turning away

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Psycho-social factors which act as barriers to accessing dental care

- Occupational stress
- Financial costs
- Perceptions of need
- Lack of access

from patients and colleagues alike (depersonalisation).[5] A dental health professional who found herself in this position was said to be suffering from 'burn-out'.[6]

The 'burnt out dentist'

Stress and anxieties together with a withdrawal of interest from work inhibit dental health professionals from providing accessible dental care for their patients.[6] The "burnt-out" dentist who encounters a dentally anxious patient will be unable to deal or help the patient cope with her dental fears. The patient's dental anxiety in combination with the dentist's own occupational stress allows a situation to occur in which barriers to providing or accepting dental care result. An example of this is the case of Mr O (Case 2). His withdrawal of interest, together with his anxiety resulted in his impatience with a dentally anxious emergency patient. Mr O was unable to cope with his own stresses and his patient's anxieties which resulted in the patient deciding to access care elsewhere.

Case 2

Mr O's dental nurse had noticed a change in his manner and demeanour in the last few months. Mr O had become withdrawn and had lost interest in his work. He couldn't even bring himself to speak to his patients. In the previous week a dentally anxious patient who arrived as an emergency was the last straw. He didn't have time for her. On previous occasions Mr O would have discussed the proposed treatment with the patient. This time he told the patient the tooth needed to be extracted and did it. The patient confided to the receptionist that she had been told that Mr O was good with nervous patients. She had thought of registering in the practice but he seemed so disinterested there didn't seem much point in becoming a patient here.

The importance of recognising that dental health professionals are constantly being bombarded by stressors allows them to appreciate the potential for 'burn-out'. Dentists who can structure their time effectively and can acknowledge their difficulties with patients and staff members are in a better position to cope with occupational stress. It is their awareness and ability to acknowledge the existence of stressors in the workplace which allows them to cope effectively with stress, prevent 'burn-out' and maintain an accessible dental service for their patients.

Financial costs

Issues associated with the running costs of a viable dental practice have been highlighted as problem areas with respect to maintaining an accessible general dental practice. Concerns and worries about how the financial viability of a practice would be affected by providing specific forms of dental care for specific patient groups has been shown to reduce practice accessibility.

The relationship between obtaining the target income and providing an accessible dental practice has been shown to influence practice policy with regard to special needs patients. Dentists in general dental practice, while providing dental care for patients with special dental needs, only do so for those who can access the care they provide.[6] Hence there remains a group of patients who are unable to access care in the usual manner. Dentists and/or practice managers have stated that their concerns about the financial burden to the practice prohibit them from providing accessible care for this sub-group of special needs patients.[7–9] Links between running costs, time urgency and stress were highlighted as factors prohibiting the provision of dental care for patients with special dental needs. With regard to providing specific forms of dental treatment, such as relative analgesia or domiciliary dental care, they again pointed to their concerns about the financial implications[10] this would have for their practices.

Viability of the practice

The perception that providing, for example, a domiciliary dental service would be detrimental to the viability of the practice was questioned by dentists who had previous or current experience of this type of service provision. A general practitioner who ran a domiciliary dental service for many years and was able to provide a range of restorative, prosthetic and periodontal treatments for his house-bound patients, questioned his colleagues' concerns. He remembered his worries about providing this type of service and how it would disturb his practice but his concerns proved unrealistic. He had managed to organise his schedule to allow the service to become an integral part of his practice profile.

He acknowledged, 'Until you have had personal experience of this type of service you think I must be mad and I'll go bankrupt but it's not like that, you just organise the visits when time's available, you work in the appointments and incorporate them into your clinical routines'.

Nevertheless time urgency and worries about income can promote barriers in some busy general practices. This was the case for Mr X and Sally. Sally aged 12 years was frightened of the drill and local anaesthetic injection. Mr X had tried on several occasions to persuade Sally to accept local anaesthetic with attempts to use relative analgesia also failing. Mr X decided to refer Sally for restorative treatment under general anaesthetic. His reasons were quite clear:

> *First, it was doing the child no good ... then it was doing me no good I started to feel irritated with her. I was wasting a lot of my time and her mother's. I kept thinking, when I was trying to give her the local, of the other patients in the waiting room and I thought I can't afford this.*

Perceptions of need

Perceptions of dental needs are based upon the clinical training of dental health professionals. The normative need[11] (see part 3 of this series) provides the basis from which treatment plans are formulated, negotiated and discussed with patients. A consequence of the identification of a clinical treatment need is that it facilitates access to secondary level care. The reason for the dentist's course of action may be related to concerns about embarking on a course of treatment. In this way the dentist is in fact reducing the patient's access to primary dental care. The decision to refer the patient with severe periodontal disease for specialist care[12] or a small child with an acute abscess to a centre of excellence for a general anaesthetic extraction is consistent with the normative need. In either clinical situation the decision to refer may reduce access to the practice but facilitate patient entry to secondary level care.

Another clinical situation exists, however, when the dental health professional's perceptions of the patient's needs are not in harmony with the patient. An example of this dichotomy may be the patient's wish for anterior restorations prior to posterior ones and the dentist's plan to complete the posterior amalgams prior to the anterior restorations. Such clinical situations as this, can be managed, with the dentist and patient arriving at an accommodation. However, when the patient insists that treatment is needed which is thought to be contraindicated, difficulties in patient management start to emerge.

A perfect dentition

An example of this is the yearning for a perfect dentition.[13] The majority of patients who present for cosmetic dentistry are satisfied and pleased with the outcome of their treatment but occasionally a patient presents who on completion of treatment is distraught and demands that the veneers be removed or the crowns replaced. The intensity and the inappropriateness of their reaction to dental care, their insistence that the crowns look ugly and ridiculous, their intense anxiety accompanied by a refusal to leave their homes suggests that all is not well. In this scenario the dentist is in the middle of a clinical dilemma. On the one hand he can see little clinically wrong with the crowns but on the other he is faced with a dissatisfied patient.

In the examples that follow the first practitioner was at a loss since she could see little wrong with the veneers she had fitted but nevertheless at the patient's insistence she removed them. In the second example the patient's odd behaviour during two preliminary consultations raised the practitioner's concerns with regard to the treatment outcome. In both situations it was the mismatch in need perception which resulted in a clinical dilemma that affected the provision of dental health care. The need for careful and sensitive questioning (see part 9 of this series) when assessing patients demanding cosmetic dentistry may be necessary in order to prevent difficult encounters in clinical practice.

Case 3

A married woman aged 40 years old had porcelain veneers placed upon her upper and lower central incisors to reduce upper and lower mid-line diastemae. The patient's appearance was greatly improved and the treatment was considered a success by all involved. When the patient returned several days later in an acutely anxious and distressed state the dentist was understandably confused as to the patient's extreme reaction. The patient insisted that the veneers were removed and, in order to help the patient, the dentist complied with her wishes. However even now several years later, the patient still feels that her teeth are deformed and that if only she could have her teeth perfect she would be free of her anxieties and difficulties.

Case 4

A married man aged 30 presented requesting veneers. On examination he had tetracycline staining which although noticeable was not disfiguring. During the history taking the patient's wife insisted that her husband had wanted veneers for at least the last 10 years. The patient remained silent. A second consultation prior to the start of treatment was suggested by the dentist. During this second meeting the patient remained silent except for an outburst when he insisted that he had always wanted perfect teeth. He felt that veneers would be the solution to his problem. His withdrawn state and anxiety during the two consultations together with his inappropriate outburst caused the dentist to have great concerns about embarking upon treatment. In particular the dentist feared the patient's response and satisfaction with the outcome of the proposed cosmetic treatment.

While mismatches in perception of need may cause barriers to be erected, sometimes the dentist's responses to the normative need together with the patients' wishes for dental care are appropriate. Acknowledging the appropriateness and inappropriateness of their responses in relation to patients' wishes will allow dental health professionals to provide accessible dental health care.

Lack of access

Lack of access as a psycho-social factor in maintaining an accessible dental practice relates not only to the physical characteristics of the practice premises (ramps, lifts, wide corridors etc.) but also to the provision of care for dentally anx-

ious patients (psychological accessibility) as well as having the appropriate auxiliary personnel.[7]

The physical accessibility of a practice has been shown to be associated with the demographic profile of the practice principal. The fewer the years in practice, the more postgraduate courses attended, the decision to provide week-end emergency dental care are all important characteristics in maintaining a practice with high physical accessibility.[7]

A similar demographic profile has been demonstrated by practitioners who provide relative analgesia services[7,10] in their practices and in this way allow for the treatment of patients with psychological special needs. Psychological accessibility also relates to the dental health professional's ability to communicate effectively with patients. This ability has been shown to be greater in younger, more recently qualified dentists and in women dental health professionals. These practitioners tended to listen more to their patients and attempt to provide care in keeping with the expressed needs of their adult and child patients.[7,10]

The dental team working together will also be able to increase accessibility for dental health care. In this regard the receptionist, the dental nurse and hygienist are invaluable. The receptionist can increase accessibility by judicious use of the appointment book. The dental nurse can increase accessibility, not only by her patient management but also in her surgery work with the dentist.[14] The hygienist working with her dental colleagues enables more patients to access preventive health care by providing the practice with her expert oral health promotion.

The demographic and patient management skills of the dental health professional are not the only characteristics which should be considered in relation to lack of access. Other salient features which should be included are surgery hours and position and location of the dental practice. It has been shown that patients use health services which are within a 6 mile (10 kilometre) radius of their homes, work or schools.[15] The relation between access, location and distance travelled has been identified by industry with many of the larger multinationals providing in-house dental care facilities — thus improving access to care. Similarly the community dental service has provided mobile dental units for school children and patients with special needs. As practice position and location are known to increase accessibility the majority of surgeries are positioned on main bus routes and located in the shopping areas. This has been developed further with a pharmaceutical company intending to provide dental health care facilities in retail locations.

Conclusions

It has been proposed that barriers to accessing dental health care exist not only in relation to the patient but also in relation to the dentist together with the characteristics of the practice. It has been suggested that within the two-person endeavour which is the dentist-patient interaction that equivalent concerns and anxieties are experienced by both dentist and patient. It has been postulated that it is this mirroring of concerns — occupational stress and dental anxiety for dentist and patient respectively — which provides the ingredients for a barrier to be erected that reduces access to regular dental care. Dentists, by being aware of the potential for the construction of barriers can, by developing their patient management skills and changing practice policy, maintain and provide an accessible dental health care service for their patients.

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