Patients are People
Treating the Person, not the Problem

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INTRODUCTION

A health-care practitioner is an individual who provides preventive, curative, promotional or rehabilitative health care services in a systematic manner to people, families or communities.[1] Sadly, many clinicians could rather be called disease treaters as they are more concerned with handling the symptoms of a disorder (which also pays the bills), than on promoting or supporting the health of the individual. This applies to an even greater extent in Dentistry where the field of focus is already small, and it is tempting to talk of patients in terms of "the tooth" or "the case". This paper presents a more holistic approach towards patient management during different stages of life from birth to adulthood.

Patients as PEOPLE

Dentists are amongst the few health care providers who treat patients throughout their lives. The first consultation is often during infancy, soon after a child's deciduous teeth begin to erupt, while the last visits may continue long after the permanent teeth have been lost, and often until death. The acronym PEOPLE can be used to guide the discussion of the many facets of a person's life that a clinician should consider during childhood, adolescence and adulthood.

P = Personality / psycho-social
E = Experiences
O = Obstacles
P = Problems (both physical and oral / dental)
L = Life events
E = Expectations

CHILDREN (BIRTH TO ADOLESCENCE)

A child's first encounter with the dentist can have a major influence on his/her future attitudes towards oral health and dental care. The dental team has a pivotal role to play in their interaction with the child patient, as well as with the parents. Ideally, the first visit should be used to establish effective communication channels, alleviate fear and anxiety, build a trusting relationship, and promote the child and family's positive attitude toward oral health care.[2] While dental practitioners are expected to recognize and effectively treat childhood dental diseases, no actual treatment should be carried out at the first visit, unless the child is in pain or has visible signs of infection. Subsequent safe and effective management requires an understanding of childhood behaviour patterns and the different child-patient personalities. A dentist who treats children should be able to assess their developmental level, dental attitudes, and temperament and to anticipate the child's reaction to care. Knowledge of behaviour guidance, communication skills, empathy, tolerance, cultural sensitivity, and flexibility are requisite to this process. The dentist should also be aware that factors such as developmental delay, physical or mental disability, and acute or chronic disease could lead to noncompliance. An uncooperative child is not necessarily a naughty child. They may merely be reacting negatively to any of a number of frightening external influences such as the smell of the surgery, the sterile ambience in the rooms, bright operatory lights, loud noises from the dental drills, and their own feeling of vulnerability. Other contributory obstacles to treatment include fear, general or situational anxiety, a previous unpleasant or painful medical experience, and inadequate preparation for the encounter. The dentist or parent should never punish misbehaviour, assert their power, force a child into compliance, or use any other strategy that hurts, shames, or belittles the child.[2] Cultural factors and language barriers can also have an effect on understanding and behaviour making it important for dentists to understand how to interact with patients from different backgrounds, and if necessary, to use an interpreter. [2]

Parents also have a major influence over their child's behaviour. They may themselves have undergone negative dental experiences and may then transmit their own anxiety or fear to their child which adversely affects his/her response to care. Sometimes parental factors such as economic hardship, depression, anxiety, irritability, or substance abuse may result in decreased protection, caregiving or discipline.[3] Positive oral health care practices should be instilled into both parents and children, as early preventive programmes will lead to less dental disease, decreased treatment needs, and fewer opportunities for negative experiences.[4,5]

Prior to beginning any dental treatment it is important for the dentist to try to evaluate the child's cooperative potential. Information can be gathered through questioning the parents, as well as by observing the child's cognitive level, temperament, personality, anxiety, fear, reaction to strangers, and behaviour at previous visits.[6] Where the child appears to be in severe pain or under major duress that cannot be managed, the procedure may have to be aborted. This is providing the procedure can safely be discontinued at that stage and that appropriate temporisation measures can be implemented to prevent further pain.

The clinician should also be sensitive to the body language of a child who is scared or in pain, but trying to conceal this in order to comply with unrealistic parental expectations (such as to not cry) or to 'please the doctor'. At the same time, "the dentist's attitude, body language and communication skills are critical in creating a positive dental visit for the child and to gain the trust of the child and their parents".[4]

ADOLESCENTS

Treating adolescent patients may require a different approach. It is often difficult to gauge their personality types, attitudes towards oral health and personal care, body image, desires and expectations. They may have unrealistically high aesthetic demands, often pinning their hopes for an improved psycho-social

life on changing their (oral) appearance. Some teenagers develop 'crushes' on adult figures and treat them as role models or potential allies, while others may be rebellious of anyone in a position of authority, including the dentist. The former will usually be very compliant with treatment and home care maintenance, while the latter may neglect their oral hygiene. This often depends on their disposition and personal circumstances at that point in time and may change from one visit to the next. The clinician should try to engage with the adolescent in an empathetic manner that will foster trust and encourage communication and cooperation. Zhou et al. endorsed using an appropriate level of physical contact accompanied by verbal reassurance to reduce patient anxiety.[7] However, the authors believe it is more prudent to avoid all forms of non-therapeutic physical contacts, and rather provide verbal reassurance along with non-intrusive and empathetic facial expressions and body language.[8]

There are a number of oral and dental problems that are germane to adolescents, being linked to their stage of dental developmental, or lifestyle. The clinician needs to be cognisant of these and alert to indicative signs during the examination. If problems are identified, they should be suitably managed by the dentist, or by referral to a specialist related to that field. The former group may include assessing the need for orthodontic treatment to improve aesthetics, masticatory function, and oral hygiene access; and monitoring third molars for signs and symptoms of pain, infection, cysts, tumours, damage to adjacent teeth, periodontal problems, or decay which may justify their removal. [9]

The latter group of problems concern lifestyle choices, including drug taking where the dentist may be the first to notice the habit. When detected or suspected the dentist has a moral and professional duty to counsel the patient. However, these practices are also often a reflection of the patient's psychosocial status. This puts the clinician in a difficult position when deciding if the parents should be informed, requiring a careful weighing up between the ethical obligations to maintain patient confidentiality versus the possible long term risks and dangers to the adolescent.

Smokers should be informed that all forms of tobacco are harmful to their oral and general health. They need to be made aware of its less obvious side effects and risks such as bad breath, stained teeth and tongue, dulled sense of smell and taste, slow healing after tooth extraction or soft tissue injury, periodontal disease, tooth loss and oral cancer.[9]

Mouth jewellery, oral piercing, tongue splitting, grillz and a number of other oral and dental adornments may be popular and fashionable, but patients need to be informed of their potential oral and general health dangers. The dentist should try be non-judgmental and authoritarian, and clearly explain how the mouth harbors millions of bacteria, which can infect damaged mucosa associated with these adornments. Serious infections from oral piercing can also lead to more serious life-threatening systemic infections, including hepatitis or endocarditis. Swelling of the tongue could close off the airway, while broken pieces of jewelry may lead to choking or be aspirated. The metal trinkets can also cause tooth chipping or complete fracture if bitten into, while grillz are damaging to tooth structure, may interfere with occlusion, and hamper adequate oral hygiene.[9]

Meth Mouth is a term used to describe the particular damage caused by the use of the illegal and highly addictive drug methamphetamine. This drug is a potent central nervous system stimulant that can cause shortness of breath, hyperthermia, diarrhea, irregular heartbeat, high blood pressure, permanent brain damage, muscle spasms, jaw clenching, nausea, vomiting and rampant tooth decay. The teeth appear blackened, stained, rotting, crumbling or falling apart, and are often unrestorable. This particular decay pattern is thought to result from users vomiting, and then passing out. The pooled vomitus which is highly acidic then bathes the teeth for hours on end. The damage is compounded in those who also consume high caffeine/sugary energy drinks, and where personal and oral hygiene is neglected.[9]

Eating disorders such as anorexia, bulimia and binge eating, "arise from a variety of complex physical, emotional and social issues, and can all be devastating to oral health". The malnutrition associated with anorexia has far reaching systemic and oral implications. The latter are all inter-related and may include altered taste sensations, burning mouth, halitosis, swollen salivary glands, xerostomia, gingival and mucosal bleeding, and cervical caries. The regurgitation associated with bulimia results in the strong stomach acid repeatedly flowing over teeth. It is particularly noticeable as enamel loss on the palatal surfaces of the maxillary anterior teeth, resulting in thin brittle teeth that may also exhibit a change in colour, shape and length.[9] Non-healing ulceration of the corners of the mouth in adolescents is a little known but common indicator of bulimia. Full coverage restorations should not be placed until the habit has been controlled as acid damage to cervical restorative margins can cause more devastating secondary caries.

In all addictive behaviour patterns, the chances of successful rehabilitation and positive outcomes are far greater if the patients receive early guidance, counselling and cessation intervention, than when the patterns have become longstanding habits.[10]

Perhaps one of the most difficult areas in dentistry is trying to manage and fulfil patient expectations. This is because they may be both unpredictable and unrealistic. During the transition from childhood to early adulthood there is often an associated increased body awareness. The face becomes the centre of attention, and impacts on the ego and self-confidence of a teenager. It is usually the first body part noticed by strangers, and regularly used by others to describe a person. Appearance can also be used to "impart an identity" onto others. In 1955, psychologist Lee Joseph Cronbach described this as the "Implicit personality theory / Halo effect" and is based on stereotypical perceptions such as: less attractive people are less intelligent; those with good teeth and appealing smiles are more sociable, popular, confident and suited to leadership positions; ugly suspects are more likely to be considered guilty and given harsher sentences; and attractive males are more healthy, powerful and fertile.[11] The media can perpetuate this further with caricatures of persons with a severe Class II malocclusion being portrayed as weak and idle and those with a severe Class III as being aggressive.

Awareness of body and facial perception is essential for dentists as the eyes and mouth are considered the two most significant facial features. This is perhaps because they are generally the first physical characteristic to be noticed, are difficult to conceal and are involved in many functions. The mouth in particular is central to life as well as being the first contact one has with others when greeting, is used for communication, expression of emotion, mastication and sustenance, speech and expression of thought.
It is no wonder that tooth aberration can have such a profound effect on a person's self-esteem, with some patients blaming any number of personal hardships on their appearance. The magnitude of this may not be related to the extent of the deformity at all. This is perhaps because the reaction of strangers to a small imperfection is far less predictable than that to a larger defect, the unpredictability being the stressor. They may also suffer from depression if the abnormality leads to teasing, or if they simultaneously have unattainable ideals of how they wish to look. Advertisers and social media feed into these vulnerabilities by promoting images of perfect smiles as good and attractive to potential partners, while people with tooth aberrations are undesirable.

ADULTS

Most adult patients will have had some form of dental contact, experience or knowledge before they present to a new practitioner. The nature of these interactions can play a major role in determining how they will approach this first consultation, with many having preconceived ideas, based on their prior encounters, about both

the treatment and the clinician.[12] It is important to differentiate between dental phobia and dental anxiety. Diagnosing dental phobia cannot be made on the anxiety level of the patient at the time of presentation, as the previous history has to also be considered. Patients with high levels of anxiety may appear non-compliant or as a dental phobic. However if such a patient is able to air any anticipatory fears, successful treatment may be possible.

A past negative incident can result in distress and apprehension about future treatment, with some patients avoiding subsequent dental visits despite being in pain. A study on African Americans adults who had experienced at least one oral health symptom in the past, for which they had avoided seeking dental care listed a variety of dental stressors. These included fear of pain, terror of needles, distress from the dental drill, anxiety about having teeth extracted, concern about contracting an illness (e.g., HIV/AIDS) from unsanitary instruments, dislike of having X-rays taken and concern that they may once again receive poor quality care or mistreatment. While negative experiences may be barriers to seeking dental care, it is often personality types and expectations that dictate the outcomes, acceptance and success of the treatment.

Obstacles to treatment may be psycho-social in nature and include both problems with access to dental care as well as avoidance due to past life experiences. Factors such as socio-economic status, ethnic backgrounds, age, and gender, perception of need, dental anxiety, and feelings of vulnerability are often the reasons for avoidance of dental care and non-compliance with treatment and preventive care. These factors do not act independently of each other but act in unison.[13] Although socioeconomic status may prevent a patient from seeking dental treatment, it is a sad misconception amongst some dentists that patients from lower socio¬economic backgrounds do not value dental treatment as much as they do other types of goods and services, and that they do not believe dental care is important.[14] Thus the barrier to utilization of dental service is financial status, while that to provision may actually be due to the interpersonal dentist-patient relationship.[14]

In other situations, the problems may be clinician-related. In Dentistry, as in all fields of work, it is always best to do a job right the first time. However, this does not always happen, and there will be occasions when one dentist is called upon to contend with problems that have been iatrogenically created by a colleague. The patient, having already suffered a bad experience, may be aggravated, aggressive, impatient, demanding, skeptical, in more pain or discomfort than before, and disproportionately cautious. He/she may also scrutinize every aspect of treatment far more critically than they did the initial work. This places undue pressure on second clinician, who is now faced with trying to restore a mutilated dentition, as well as placate an emotional patient. The task is made even more onerous in situations where the patient's funds have been exhausted. As the saying goes "If you don't have time to do it right, make sure you are ready to redo it later".

Life happens, and events in life will impact on dental access, utilisation and outcomes. Barriers to seeking care may be due to financial, time, transport, family or physical constraints. These factors may also impact on how the clinician handles disparities between desires, needs and hopes. While past negative experiences may be barriers to seeking dental care, it is often life events, personality types and expectations that dictate the acceptance and the outcomes and success of the treatment.

A Google search on "Personality Types" will reveal more theories and classifications than there are implant systems on the market. No clinician can ever accurately assess a patient's nature, and almost every dentist will have an unhappy story-or ten… to tell about how they misread someone's disposition, resulting in a failed treatment outcome. However there are a few common Red-Flags!

Beware the patient who: has sought dental advice from other dentists/friends/family members/ work colleagues/glossy magazines/any of the Kardashians or Dr Google before seeing you; who flatters you excessively; who arrives bearing gifts; who promises gifts after treatment; who arrives bearing a bag of old dentures; who promises to bring in old dentures and never does; who runs down all previous dentists; who has sued previous doctors; who is related to a lawyer and makes a point of telling you this; who is getting married in a week but needing a year's worth of treatment; who is going overseas in a week but also wanting a discount price; who comes in with pictures of movie stars / old photographs and wants to look like the star / their teenage self; who is clearly disinterested; who is over-willing to please; who defers all responsibility and decision making to you, and finally – the one who is also a family member!

CONCLUSION

Patients are not mouths, cases, teeth, numbers on a file, jobs or problems. Patients are people. Like you and I, they have lives, families, jobs, homes, dreams and expectations. They have lived through many events, may be dealing with current issues, and all have an unknown road ahead. Take the time to communicate, get to know them, and try to manage them in a holistic manner while still maintaining your professional and ethical demeanour.

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