COMMUNICATION IN DENTAL MEDICINE: IMPORTANCE IN MOTIVATING ELDERLY DENTAL PATIENTS

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COMMUNICATION IN DENTAL MEDICINE: IMPORTANCE IN MOTIVATING ELDERLY DENTAL PATIENTS (Abstract). Dental services for elderly patients are characterized by a series of particularities related to the vulnerability of this age group, which is affected by various comorbidities, and the diminished physical, cognitive and financial capacities. Finding ways to keep elderly patients coming to a dental office is possible by improving the dentist-patient relationship and implicitly the quality of care by increasing the self-esteem of the elderly and their place in society, by increasing the role of oral health in the quality of life, and here we refer to the pleasure of eating, the pleasant physical aspect and normal diction. The present paper presents the psychological aspects that interfere in the communication process between the dentist and the elderly patient and the changes motivation undergoes when people are in pain. These data can sometimes change the reticent attitude of the dentist towards the elderly patient which is often considered to be a risk patient.

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Ageing is a continuous, gradual process which begins at birth and continues over the lifespan. It represents the irreversible inherent progressive alteration of many body functions which cannot be eliminated and which increases the individual vulnerability. Ageing presents both positive and negative aspects. These is not a specific age to clearly mark the beginning of old age, but the phenomena related to ageing are widely presented in the literature dealing with this subject, although the mechanism by which the human body is getting older is not clearly known, yet.

Generally, the ageing processes affect differently the structure and the functions of various organs and tissues. The modifications refer to either the degradation of anatomic structures accompanied by the survival of others which are provided with a compensatory activity, as it is the case of nephrons or muscle fibers, or by the continuous loss of neurons, followed by the gradual decrease of sensitive-sensory and behavioral abilities.

The particularities of the third age have lead to the necessity of organizing departments of Gerontostomatology within the schools of dentistry. This way, dentists will become familiar with the specific features of the dental services for seniors. Moreover, it appears that dental care for other age
groups has a certain impact on the elderly patient too; it is considered that if teeth are properly cared from childhood the better the oral hygiene will be later on in life, because the lack of dental hygiene affects teeth more than the process of ageing (1).

The fall out of teeth is more frequent at the level of the upper jaw, consequence of dental caries or periodontal disease. Water fluoridation and better oral hygiene, reducing the frequency of caries and bocco-dental infections can avoid or delay edentation in the elderly. The process of dental degradation affects both the enamel, which becomes pigmented and gradually lost through attrition, and the dentine, whose odontoblastic activity reduces the pulp cavity up to complete obstruction. To these, the weakened periodontal ligaments, gingival atrophy and bone resorption at the level of the alveolar area are added.

The oral mucosa presents a certain degree of atrophy and dryness due to the low quantity of mucin and saliva. The filiform and circumvallate papillae on the surface of atrophic tongue decrease taste sensibility by almost 30% by the age of 70.

If we refer to the elderly, during the process of oral care, the patients are not the only ones who must be motivated, but the dentists as well since their attitude towards the elderly often reflects the negative stereotypes society has in their respects (2). This attitude is represented by the refuse to treat the elderly patient, seen as a high risk patient due to the numerous co morbidities, or because the various dental procedures have to do more with removing than with preserving, extraction, with its mutilating effects, being chosen over treatment. In the young population, edentation is the oral affection with the highest impact on self-esteem, and it plays an important role in patient motivation. If dentists were familiarized with the physical and psychological features of ageing, they would no longer consider third age patients as part of the less important cases.

The dentist has the moral and professional duty to create, from the first contact and during the entire process of examination and care, the best climate for cooperation, based on transmitting a feeling of confidence regarding the positive evolution of the disease, patient’s healing and his family and social reintegration. Self-esteem (behavior and attitude) stands at the base of the doctor-patient relationship and it represents the first condition for therapeutic success.

For humans, communication represents the main mean of socializing, his personality being structured in his own communication area.

The purpose of communication is that of making the interlocutor feel, think or act in a certain way. The purpose exists even if the partners of communication are not conscious of it (3).

Within the doctor-patient communication relationship, the doctor must be able to recognize and properly decipher the patient’s verbal and nonverbal messages; to use the proper verbal and nonverbal communication means for transmitting information to the patient, depending on the nature of the message and context (severity of the disease, type of patient, emergency etc.) (4).

The essence of communication consists in eliminating patient’s and doctor’s uncertainty regarding the nature of the disease; clinical uncertainties (when there is clear uncertainty regarding the diagnosis and its prognosis) and functional uncertainties (when the doctor knows both the diagnosis
and the prognosis, but he keeps the patient and his family in a state of uncertainty for not being forced to reveal unpleasant information to the patient).

Dental medicine must become an active part in knowing the oral involutive physiological and pathological processes for being capable of creating geriatric prevention programs.

**PATIENT MOTIVATION**

Patient motivation is one of the least understood aspects of treatment but also one of most importance.

The components of the motivational system are numerous and vary in their origin, way of satisfaction, and functions. Human motivation includes needs, reasons, interests, convictions, tendencies, intentions, desires, and aspirations. The elements indicating a state of physiological or psychological unbalance are the tendencies. They are experienced as states of agitation, inner alert, tension (5).

If an obstacle prevents a need from being satisfied, then a state of tension appears; this is called frustration. The answers to frustration are different, the most frequent one being represented by aggressiveness. Frustration is unavoidable in psychic life; when moderated, it has positive effects on the development of personality. Thus, the impossibility of fulfilling love due to social status differences can stimulate the fight for climbing the social hierarchy. Given the unavoidable nature of frustration, balanced personalities manifest tolerance to frustration, supporting, within certain limits, states of intense tension without developing pathological behaviors.

Quite often, patient motivation is wrongly understood as the technique which changes patient behavior and not a change in patient perception of treatment importance and impact. The main idea is to reach that phase in which after becoming aware, the patient manages to motivate himself; this can be achieved if the clinician uses and stresses the right words in order to achieve a dramatic impact on patient’s psychic.

One of the difficulties encountered in motivating the patient is that certain words mean different things depending on the person, and many times patients in need of motivation are those who do not need many instructions. What they need is not motivation, but the reason for which the doctor has given them those instructions.

**THE BASIC STRUCTURE OF MOTIVATION**

For achieving the desired result of a certain action, it is compulsory for that action to be determined by a reason. The patient must be aware that the action is right for achieving the desired result. Although the patient may be aware of these things, inner feelings may interfere with the motivational process, attitudes which influence the decision of taking action or not, so that in the end the decision will depend on inner or environmental factors.

Failure of motivation can rely on the existence of various aspects with weak structure and which can be disintegrated (6). For example, patients who do not want to change the way they perform their oral hygiene but who pretend to do it.

The positive influence on the patient could be obtained by advising him about the correct oral hygiene, identifying the reasons for which the patient is reticent, and the transformation of the doctor into a psychologist who understands the patient.

The doctor, as a good psychologist, will
get close to the patient in the latter’s best interest. The doctor’s affective openness towards the patient eliminates anxiety and uncertainty and humanizes the medical act.

Each patient has his own personal reasons for performing a correct brushing, and the doctor can make sure the patient maintains a correct oral hygiene. The confidence in diagnosis can be reached using a large variety of methods, from the simplest to the most complex, but in general, the diagnosis is set after a good relationship is created between the doctor and his patient.

The internal influences which affect motivation include the patient’s feelings and attitude. If the patient has tried and managed to improve his oral hygiene, then the patient is more confident in the concept of oral hygiene. If the patient realizes that he plays an important part in any type of communication with the doctor, he will provide positive feedback. Generally speaking, the patient’s attitude is the result of other frequently underestimated experiences and which can influence motivation.

External influences are probably the most important, and the patient’s motivation in maintaining the action or modifying the behavior depends of life style, inner pressure and the influence of the external environment.

There are three key concepts which will be taken into consideration for the best result possible: communication, environment and attitude.

**Communication** plays an important role in motivating the patient. It represents the ability of communicating with the patient for stimulating behavioral changes. If the patient initiates a change in his behavior, he must be helped by the clinician to obtain the expected effect. In fewer words, communication requires knowing personal attitudes and also the ability of listening to others.

The importance of the environment - apart from the feelings of both parties there is the physical situation of the patient in the dental chair frequently in decubitus, a position seen as uncomfortable and stressful. A consequence of this uncomfortable position is the fact that the patient is no longer interested in listening and understanding the advices received.

The position at the same level will give the possibility to achieve a positive result in motivating the patient. The non-verbal language will be considered as well: body language, smell, noise.

**Attitude.** Improving the motivational aspect is a job of the entire medical team, the purpose being sometimes difficult or even impossible to achieve. One monitoring method could be represented by the use of forms and indices systems. Thus, the patient is informed about the necessity of these measurements and the need of maintaining their values. After recording the indices, they are presented to the patient at each visit having thus the possibility to analyze the patient's effort and the results achieved.

In case the patient does not respect the indications provided, in time he will notice the appearance of complications and he will be interested in remedying the situation. Because the indices used are highly sensitive, the patient will notice the situation improves and he will be more confident with the treatment and the positive solution of his disorder.

The “self-assessment” concept implies encouraging the patient to monitor himself at home.

**State of mind** is an important element as far as quality of life is considered. Elderly
people, although they don’t recognize it, are unhappy because they have lost their social status, are no longer important and respected. Elderly people realize that with the passage of time they lose the importance they once had in their social relations, due to the fact that they are no longer that active in fulfilling their role in society. Slowly, they lose the role of parents, they withdraw, suffer from chronic diseases and they must deal with the conditions imposes by their new status of pensioners.

Sadness can easily be considered a characteristic of old age. Nevertheless, this does not mean it has to be ignored. Many times elderly people are so sad that they no longer take care of themselves and thus they hurry their end; some of them even decide to commit suicide. Deficitary oral health for the elderly patient can be due to the anxiety caused by painful medical interventions, uncertainty regarding their physical aspect but also to the social isolation in which elderly people often live (7).

Another aspect of the elderly patient’s motivation in improving the communication with the dentist is represented by the need of maintaining the integrity of his oral health, determined by social and psychological factors. At more advanced ages, when the work volume decreases, eating becomes one of the few pleasures of life (8). At the same time, contemporary society promotes youth, prolonged also through plastic surgery. Apart from the aesthetic consequences, oral rehabilitation facilitates a clear pronunciation, far from the nasal incomprehensible speech which is maliciously associated to old age. That is why, the number of remaining teeth, the use of prostheses or not, the level of education, social status and rural or urban native environment influence the frequency with which elderly people come to the dentist’s office.

**CONCLUSIONS**

Motivation is an inner process and not an imperative which can be imposed from the outside, and communication creates the bridge between the two, doctor and patient. Unlike the young patient, elderly patients tend to avoid discussing with the doctor subjects related to their emotional states as they consider a consultation to be referring strictly to solving medical problems; they do not see the doctor willing to approach this kind of subjects or they consider these discussions as a violation of their privacy. The increased severity of oral affections and the difficult access to medical services, caused by either health issues or difficult financial condition which came along with retirement, turn the elderly patient into a vulnerable category. Hence, the psychological aspects become key elements in the medical act addressed to elderly patients.

**REFERENCES**

TOPICAL XYLITOL ADMINISTRATION BY PARENTS FOR THE PROMOTION OF ORAL HEALTH IN INFANTS: A CARIES PREVENTION EXPERIMENT AT A FINNISH PUBLIC HEALTH CENTRE

Xylitol has been shown to be an effective tooth decay preventive agent. Clinical studies of xylitol have almost exclusively involved chewing gum or lozenges and evaluated school age children and tooth decay in permanent teeth. This demonstration programme tested topical use of xylitol as a possible oral health promoting regimen in infants at a Finnish Public Health Centre in 2002-2011. Parents (usually mothers) began once- or twice-daily administration of a 45% solution of xylitol (2.96 mg) onto all available deciduous teeth of their children at the age of approximately 6-8 months. The treatment (xylitol swabbing), which continued till the age of approximately 36 months (total duration 26-28 months), was carried out using cotton swabs or a children's toothbrush; the approximate daily xylitol usage was 13.5 mg per each deciduous tooth. At the age of 7 years, caries data on the deciduous dentition of 80 children were compared with those obtained from similar, untreated children (n = 90). Xylitol swabbing resulted in a significant (P < 0.001) reduction in the incidence of enamel and dentine caries compared with the comparison subjects (relative risk 2.1 and 4.0, respectively; 95% confidence intervals 1.42-3.09 and 2.01-7.98, respectively). Similar findings were obtained when the children were 5 or 6 years old. The treatment reduced the need of tooth filling relative risk and 95% confidence intervals at 7 years: 11.86 and 6.36-22.10, respectively; P < 0.001). Compared with untreated subjects, the oral counts of mutans streptococci were reduced significantly (P < 0.001). Considerable improvement in dental health was accomplished in infants participating in a topical at-home xylitol administration experiment, which was offered to families in the area by the Public Health Centre as a supplement to standard oral health care. This study is the first to demonstrate that xylitol topical syrup at 8 g per day divided into two or three doses given during primary tooth eruption in children 15 to 25 months of age reduces tooth decay and could prevent up to 70 percent of decayed teeth. Caregiver assessment of the programme was mostly rated as high or satisfactory (Mäkinen KK, Järvinen KL, Anttila CH, Luntamo LM, Vahlberg T. Topical xylitol administration by parents for the promotion of oral health in infants: a caries prevention experiment at a Finnish Public Health Centre. Int Dent J 2013; 63(4): 210-224).

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