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Barriers to accessing and accepting dental care

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This paper looks at the psycho-social factors influencing patients use of dental care, and what the dentist can do to help when things go wrong.

Dental health professionals often experience difficulties when they try to help their patients acquire and maintain actions which are conducive to preserving their dental health. Nevertheless despite repeated attempts there may be no change in the patient's behaviour and indeed occasionally some patients may seem to deteriorate rather than improve. The patient may feel criticised while the dentist may feel there is little point in continuing. Feelings of hopelessness and despondency colour the dentist–patient interaction with the patient being thought of as impossible and non-compliant.

The patients' behaviour, however, is only one aspect of the non-compliant story. The other parts of this tale are to be found in the patients' life experiences and personal histories. The difficulties patients experience when trying to comply with dental health advice are not conjured up for the here and now but have their roots in earlier times. For instance, they may be associated with the era in which the patient grew up or with how highly their family rated dental health care amongst other competing lifestyle priorities, or perhaps they were related to previous unfortunate dental health care experiences. All of these factors would affect the patients' feelings, beliefs and attitudes with regard to complying with dental health care.

These are the psycho-social determinants of dental health attitudes and behaviour. They not only form the kernel and impetus for an individual to adopt a particular dental health action, but they may also provide the basis for the formation of obstacles to accepting and accessing dental health care. In this way it may be proposed that these psycho-social factors could be likened to 'a knife that cuts both ways'. On the one hand they may allow the patient to modify or change their dental health actions, while on the other, they may act as obstructions which seem to block any modification in health behaviour.

In order to examine the role of psycho-social factors as obstacles or barriers to behaviour change, one dental health care action that could be considered by way of illustration is dental attendance. By thinking about dental attendance as a health care action, it is evident that three perspectives must be considered. These are from the patient's perspective, the professional's perspective and that of society.[1] It is beyond the remit of this paper to discuss societal barriers of dental attendance other than to state that they exist.

It is the aim of this article, to describe what is meant by barriers to accessing and accepting dental health care. Examining the content of these barriers allows the dental health professional to take the next step in understanding their patients' difficulties when complying with dental health advice.

Psycho-social factors as barriers to accessing dental health care

When considering the need for regular dental attendance, it is apparent that there is a discord which exists within the profession. While there has been little dispute with regard to the role of sugars in caries, the importance of fluoride use in the prevention of dental caries and the removal of plaque in the promotion of periodontal health, the same cannot be said for the regular dental examination. Argument and debate concerning the appropriateness and effectiveness of regular dental attendance have captured the minds of the profession and public alike. Concerns about the effect of regular dental attendance upon oral health has resulted in a number of opinions ranging from those who perceived it as a integral part of peoples' health behaviours,[2,3] to those who viewed it as dental hegemony.[4,5] Irrespective of the rights or wrongs of the debate, the fact remains that some people are unable to attend for dental care on a regular or routine basis.[6,7] The reasons for their inability to access care in the usual way need to be answered.

From the 1980s through to the 1990s[8,9] studies were conducted to find out why this state of affairs existed. The word barrier replaced the word obstacle and was coined as a means of conceptualising the difficulties people experienced when accessing dental care. Nevertheless it led to the idea that one factor relating to access to dental care could be thought of in physical terms. For some patients, physical problems did arise (for example, managing stairs) when trying to gain access to the dental surgery. For some dentists physical barriers

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existed with regard to the inequity of services. While, within society, as a whole, insufficient political support for health care funding could influence availability of dental services.

To think of barriers as mere physical structures barring the patient's way for treatment, excludes the role of psycho-social factors as obstacles to dental attendance.[4] In this respect, psycho-social factors acquired a passive connotation rather than in their usual guise as active components associated with developing and evolving health attitudes and behaviours. Barriers to dental health care could now be considered as static factors which reduced the patient's entry to the dental surgery and treatment. In this way psycho-social factors provided a framework around which dental health professionals could plan their strategies to develop and maintain accessible dental practices for their patients.[1]

The Federation Dentaire Internationale[1] (FDI) suggested that three separate category of barrier should be considered. The first of these related specifically to the individual and included:

> 'lack of perceived need, anxiety and fear, financial considerations and lack of access'

The second category related to the dental profession. They included:

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

The third and final category of barrier related to society:

> 'insufficient public support of attitudes conducive to health, inadequate oral health care facilities, inadequate oral health manpower planning and insufficient support for research'.

Within the two person encounter, which is the dentist–patient relationship, the psycho-social aspects of the barriers to the receipt of dental attendance are particularly important. Attitudes, concerns and financial responsibilities act as barriers with regard to accessing (the patient) and providing (the dentist) dental care. For society as a whole, norms in relation to the importance of dental health care affect regularity of dental attendance.[10]

If practitioners are to care for patients with special treatment needs it was necessary to consider how psycho-social factors[11] influence the patients' ability to access dental care, how the dental health professional's concerns about practice viability affect treatment choices and referral patterns[12] and how societal influences[10] affect access to dental health care.

The FDI classification of barriers reflects their psycho-social composition. Thinking in this way provides the means by which barriers to accessing dental care could be understood, first from the patient's and, secondly, from the dental health professional's points of view. This gives practitioners an increasing understanding of the difficulties they and their patients may experience when they, respectively, provide and access dental care.

Resistances as barriers to accepting dental health care

Another more flexible or dynamic view of barriers to dental health care exists and these have been referred to as resistances.[13] Resistances are said to exist within the dentist-patient relationship and are subject to changes in intensity. Resistances can therefore strengthen or weaken the treatment alliance. Essentially they may act to prevent the patient from progressing from accessing care to accepting dental treatment.

It is proposed that to understand the concept of barriers to accessing and accepting dental care these two models must be considered. The first is the psycho-social model. It provides a means by which practitioners can formulate policy to allow them to develop and maintain accessible general practices. The second is a psychodynamic model based upon the concept of the resistances. By understanding this concept, dentists will be able to appreciate the difficulties their patients experience when accepting dental care. By acknowledging the presence of resistances, they will be able to strengthen the treatment alliance. An awareness of the psychodynamic model of barriers to dental care provides the dental health professional with an appreciation of what barriers mean for their patients and the dentist–patient interaction.

When the patient has accessed dental care (s)he must make a decision about accepting the suggested treatment. It would seem that at this point in the dentist–patient interaction the quality and character of the barrier has changed. It can now be thought of as a dynamic force opposing the forward progression from accessing care to dental treatment. In this way barriers are conceptualised as 'resistances'. Resistances are not static obstructions but ebb and flow in accordance with the patient's feelings, worries and anxieties, on the one hand, and the desire for treatment on the other hand. The dynamic character of the resistances permits them to use any fears, concerns, difficult circumstances or situations that patients may experience to prevent them from accepting dental treatment. In other words any tactic will be used to prevent accessing care and hence cause a delay in treatment. Adults, for instance, may use the opportunity of a sudden upsurge at work to cancel an appointment or may just simply forget to come to the surgery at the appointed time. The case of Mrs M is illustrative (Case 1) in this regard in that by forgetting to bring her partial

denture to the surgery she delayed the date of a feared extraction.

Case 1
Mrs M was 35 years old and as a result of an accident needed the extraction of her upper, right, central incisor. It was decided that she would have an addition to her spare partial denture so that it could be worn immediately after the extraction. An appointment was made for impressions. Mrs M arrived but had left her denture at home. Although Mrs M had seemed to accept the need for the extraction of her upper central incisor her actions (leaving the denture at home) betrayed her true feelings. A resistance based upon her fears of how she would look after the extraction was the basis of forgetting her spare partial denture. Treatment had been delayed.

However to present the view that the resistances are all powerful and destructive would be to ignore the patient's wishes for dental treatment. It is not that the patient does not realise that the dentist is there to help or that the patient does not wish to have the treatment, it is that his fear counteracts this wish and prevents the forward movement to accepting regular dental care. To enable the forward progression from accessing care to accepting treatment the patient must be able to allow that part of herself that wishes for care to outweigh the resistances (the worries, fears and anxieties). The following is a common place observation and illustrates the patient's indecision or conflict in this regard:

> 'A man who has gone to the dentist because of an unbearable toothache will nevertheless try to hold the dentist back when he approaches the sick tooth with a pair of forceps.'[13]

In the above the man's fears of the extraction (the resistance) were nearly enough to prevent the extraction of the 'sick tooth'. The resistances are barriers which need to be got over. Some patients, irrespective of the difficulties encountered, overcome their resistances and attend for dental treatment. This was the case for Mrs L (Case 2) who despite having to organise child care for the afternoon of the appointment still managed to be at the surgery at the appointed time.

Case 2
Mrs L ran into the surgery, fearful that she was late. She told the receptionist that there had been a mix up with her child care. Her mother who lived close by was to mind the children for her but she was sick. This meant contacting her mother-in-law who lives two bus journeys from her home, getting the children ready and then getting the two buses back to the surgery — she was whacked! She was looking forward to the rest in the chair before her return trip.

Resistances in children are contemporaneous with the stage of the child's personality development. The child's behaviour will betray his thoughts, worries and feelings about dental treatment (Case 3)

Case 3
An amusing example of some children's ingenuity in order to avoid a visit to the dentist is illustrated by Tim aged 8. His mother had asked an aunt, who did not live in the town, to pick Tim up from school and take him to the dentist. Mother reassured the aunt that Tim knew the exact location of the surgery as he had been there on many occasions. The surgery was in fact sited in the street next to the school. Tim was collected at the agreed time. He told his aunt that he was not sure as to the correct location of the dentist and he would have to search for it. He walked his aunt around and around the neighbourhood for 30 minutes. Suddenly, as if by magic, Tim came upon the surgery. He was now too late for the appointment and had effectively delayed treatment to another time.

Other children will delay the start of treatment by talking incessantly. Another clinical situation exists with young children. Young children who cannot differentiate between the pain caused by the suffering of their sore teeth and that caused by treatment, or those with learning difficulties who may not understand what is happening,[14] may refuse dental treatment. In conjunction with mother's agreement the best course of action may be to facilitate referral to secondary level care. Such was the situation for Diane aged 11 who had learning difficulties:

Case 4
Diane's dentist was fond of her but had failed in his attempts to enable Diane to accept the dental care he was trying to provide. Diane could just about tolerate a mirror in her mouth. Diane's verbal capacity was poor and she was unable to tell the dentist how she felt. It was apparent that the dentist's attempts to enable Diane to accept care had failed and in agreement with her mother it was decided to refer Diane for specialist dental care.

Dental attendance patterns may also be upset during adolescence. Adolescents who perceive the dental health professional as yet another parental figure imposing their will upon them, may miss scheduled appointments. The above actions are indications that resistances are at work and should alert the dentist that all is not well. The patients' actions will provide the practitioner with the means to counteract the effect of the resistances and hence strengthen the treatment alliance (see parts 2 and 4 of this series). Observing the patients' behaviour and actions may prevent them from erecting

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11 Gift HC. *Social factors in oral health promotion*. In Oral Health Promotion (Eds. L Schou, AS Blinkhorn): Oxford:. Oxford University Press: 1993.
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13 Freud S. (1917) Resistances and repression. In *Introductory Lectures on Psychoanalysis*. Penguin Books, Harmondsworth. 1976.
14 Freud A.(1952) The role of bodily illness in the mental life of children. In *The Selected Anna Freud* (Eds. R Ekins, R Freeman) Penguin. Harmondsworth. 1998.

barriers and missing scheduled appointments.

Resistance is a dynamic way of conceptualising barriers which exist and prevent the progression from accessing to accepting dental care. The resistances use any means available to form a barrier to prevent the patient accepting dental care. In this way they may become the practitioner's greatest enemy. However as patients' actions and behaviours betray their true feelings about the proposed treatment, resistances may become the dentist's greatest support. The recognition of resistances in the form, for example, of forgetting, alerts the dentist to the patient's concerns about treatment. Discussing with the patient about her worries allows the dental health professional to strengthen the treatment alliance by formulating and negotiating treatment plans with which the patient is able to comply.

The acceptance of treatment plans includes compliance with preventative regimes. Therefore an understanding of the resistances within the dentist–patient interaction allows the dental health professional to appreciate the patient's ambivalence when attempting to change his health behaviours (see part 10 of this series).

Conclusions

It has been suggested that barriers to dental health are the passive aspect of the psychosocial determinants of health attitudes and behaviours. These factors may assist in behaviour modification or act to prevent any forward movement to accessing or accepting health care advice.

One specific dental health action was considered — regular dental attendance. It was clear at the outset that an obstacle existed at a professional level since dentistry itself was divided with regard to the appropriateness of regular dental attendance. Nevertheless since the 1980s, the work by Finch and colleagues[8] on the barriers to accessing regular dental care has led to an examination of the factors used by patients and dentists alike to inhibit and reduce access to dental health care.

The idea that barriers were erected not only as a result of the patients' psycho-social background but also as a consequence of professional attitudes and characteristics was voiced by the FDI[1]. This suggested that as the dentist–patient interaction was a two person endeavour, barriers must also be considered within a two-person framework. It would be within this two-person framework that barriers to accessing and accepting dental care could be conceptualised.

It has been proposed, that barriers of a different character or quality exist in relation to accepting dental treatment. Barriers to accessing and accepting dental care are the same but possess different characteristics or qualities. First, there are those which are psycho-social in their character and are related to accessing dental care. Second there are those which are more dynamic and act within the dentist–patient relationship. These latter barriers or resistances, which may or may not also include psycho-social factors (for example, dental anxiety), reduce the patient's ability to accept dental care thereby weakening the treatment alliance.

It is by an appreciation of the character of the barriers to first accessing and second accepting dental care that dental health professionals can help their patients adopt behaviours conducive to oral health.

Correction

In *BDJ* Vol.186 **12**, June 26 1999, pp638-640 in the paper 'Dental education and the European context', by J Scott, the first sentence of the abstract at the start of the article was printed incorrectly missing the words 'from Europe'. The correct version of the abstract is printed in full below with the omission in bold. We apologise for any inconvenience caused:

"Two hundred and sixteen additional dentists enter the Register **from Europe** annually. Dental educational standards vary widely across Europe. Convergence is best promoted through exchanges (SOCRATES) and voluntary school visitations (DENTED). UK standards are set by the GDC and maintained by the schools. Consequently no schools should be closed in response to current immigration levels by European dentists."