INCREASING DENTAL PATIENTS’ ACCESS TO MEASURES FOR ANXIETY, FEAR, AND PHOBIA MANAGEMENT

Perspectives of Dental Education

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Until the mid-1960s the dental profession estimated that but 40% of the U.S. population sought regular dental/oral health care. Since that time, the percentage of the population seeking care has risen to nearly 50% of the total population. This improvement has been due to a number of factors and incentives such as increased educational status of the population, better recognition of the value of dental/oral health care, and third party involvements in costs of care. In recent years the national expenditure for dental/oral health care has steadily increased with recent figures of the Health Care Financing Administration predicting expenditures in 1985 of $27.2 billion, up from $21.8 billion in 1983.

Throughout professional history, there has always been a segment of the population which does not seek care because of related dental anxieties, fears, or phobias. This segment has been variously estimated at between 8 and 15% of the population. As near as can be determined, this figure has remained relatively constant over the years—which is, in some aspects, quite remarkable. If that percentage is not increasing, something positive is happening in the environment since one might expect that those with fears would, in some way, transmit those anxieties to others, especially children. It could, therefore, be argued that some portion of the 25% increase in national dental expenditures over the two-year period 1983 to 1985 could be due to the professional recognition of some causes of anxieties and professional attention to this aspect of patient management. While this is most laudable, much still remains to be achieved. If the percentage of the population with dental fears and anxieties is remaining relatively constant, there is, obviously, a flux of patients into and out of this population, and that population includes hundreds of thousands of patients in probable need.

Over the past 25 years, dental schools have increased considerably their required curriculum time in behavioral sciences. A portion of this time is spent in didactics concerning anxieties, fears, and phobias. Some clinical techniques for the management of this spectrum of behavior are taught and utilized to some degree. The amount of such clinical activity ranges from very little to full special care clinics for the identification, classification, and treatment of the problem. Nonpharmacologic techniques such as desensitizing procedures, hypnosis, and the various forms of counseling are utilized. Schools have been the most effective (to the thinking of some) in the pharmacologic approach to management which is also one method of approaching treatment of fears. Thus, schools have histories of providing predental students with some fundamentals relating to the management of dental phobics. This has not, as mentioned in a previous conference, been a major thrust of most schools.

Many factors contribute to the less than adequate utilization of techniques for diagnosis and management of the dental phobic by predental students. Most of these are well known to dental educators—such things as cavity preparations, periodontal treatment and the general array of education and training necessary to meet the requirements for graduation and board examinations. On the list of dental student priorities, time spent in dealing with “uncooperative” patients does not get too high a rating. This is not to say, however, that stu-
dents are not interested. They indeed are, but the educational system forces choices on them.

Furthermore, the recalcitrant patient is not high on faculty priority lists either. As faculty members pursue their daily activities of lectures, seminars, laboratory supervision, clinical supervision, and general school functions, they find little time for the identification and referral of these unfortunate patients to persons whose interests are in this area.

Finally, at the far end of the fear spectrum, are the truly phobic individuals who do not present for treatment. They do not expose themselves unnecessarily to treatment and seek care only on a dire emergency basis. Thus, their overwhelming fears result in their being dental cripples and the sequelae attendant thereto.

From the foregoing, the solution to the problem seems quite simple: increase curriculum time in behavioral science education, create the clinical environment to enhance the transfer of knowledge to applicable skills, educate the faculty further in the recognition and identification of the anxious/phobic patient and refer the patient to the resources available, locate and hire adequate numbers of faculty educated and trained to teach the concepts and supervise the clinical education of students in this problem area, and finally attract sufficient numbers of anxious/fearful/phobic patients to the school to provide the volume and variety of patients necessary for adequate learning. Obviously, in this solution the tail is wagging the dog and the problem continues to exist.

Dental schools in recent years have been establishing centers for TMJ dysfunction management, pain centers, centers for craniofacial and/or cleft palate management, etc. Each school should probably develop centers for the problems associated with the dental phobic patients. The composition of these centers is well known to you and include people trained in the identification, diagnosis, and management of the full spectrum of dental fears and provide for pharmacologic and nonpharmacologic modalities. Such a center would not only serve the patient but would also provide the setting for the further sensitization of faculty and students to this problem area. Once such a center is established various methods of information dissemination could be employed to attract the anxious/phobic patient.

In order to achieve this end, education and training programs must be broadened to enhance the corps of practitioners necessary to meet the needs. This would require more programs for behavioral scientists, more programs to develop people skilled in the pharmacologic approach, more programs to man (or woman) all the areas involved. As these centers become functional, new areas of research will be identified to bring a more precise definition of the problem as well as suggesting new and better ways of management. Additionally, cooperative research between and among centers using comparable protocols could provide a much greater data base and add more validity to the studies.

Pain and fear have been the hallmarks of dentistry from antiquity. Today the profession is at a stage of evolution where it can bring oral health care to all patients in a more patient-acceptable fashion than at any time in history. How far along the road we are to mastery of the situation no one really knows. What is known is that some end-point is within striking distance and must not be left to falter now.

References