DENTAL CARE FOR THE ELDERLY

Edited by Bertram Cohen & Hamish Thomson

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Preface

No spring nor summer beauty hath such grace
As I have seen in one autumnal face.

John Donne

This book has its origins in a meeting held at the Royal College of Surgeons of England in 1983. An all day symposium entitled 'Three Score Years and Then?' was devoted to Dentistry's last priority and, despite the gloomy forebodings of those who predicted that there would be no audience for a topic of this sort, the attendance exceeded the previous highest for meetings in this series. We interpreted this response as recognition of the growing need for devoting more time and more attention to elderly patients. Hitherto the teaching of dentistry and of dental public health education has directed an overwhelming preponderance of its attention to childhood and early adolescence, to the extent that care for the elderly has come to be neglected – both relatively and absolutely.

The current increase in numbers of the elderly has resulted from improved social conditions, advances in the control of illnesses formerly fatal and more positive medical care. Death is no longer taken for granted after 70 and a greater effort is made by sons and daughters, often in their fifties and sixties, to provide room and board, comfort and compassion for their parents and more of this will be required in the years to come when many of today's middle-aged population, spared from wars and epidemics, reach the often youthful age of 70 with the prospect of 20 years ahead.

According to the 1981 census, 17.7% of the British population were of pensionable age. Of these the highest proportion was in the Southwest (20.7%) and the lowest in the West Midlands (16.1%). The expectation of life at birth has risen to 76 years for women and 70 for men. The number of those over 75 is expected to continue rising up to 1986 when women will outnumber men in a ratio of 3:1. The greatest percentage increase will be in those of 85 and over (43.5%). The absolute numbers of those over 75 will rise from 2 280 000 to 3 000 000 by 1991 and the over 85s will increase from 400 000 to 600 000 by the year 2000.

The young elderly (between 65 and 74) do not differ markedly in health status from the younger population, but after 75 disease

and death rates rise steeply. One-fifth of those aged 85 and over are housebound or permanently in bed and mental infirmity in this group presents a serious problem; 2% have severe visual impairment and 3% have difficulty with hearing. Women have a greater expectation of life and two-thirds of women over the age of 75 are widows. Undue concentrations of lonely and isolated old people exist in the inner zones of large cities and in retirement areas. To assume that they are invariably members of a family group is a mistake that can lead to their being overlooked despite the best intentions to care for them.

It is disturbing to read in medical literature of the high proportion of elderly patients suffering from dental disability. Advice on care of the teeth often has to be provided by the medical practitioner, as part of total medical care. Neglect of oral hygiene and a high proportion of edentulous patients are commonly seen and it is often difficult for geriatricians to find dental practitioners to care for these patients.

Thus challenged, dentists must be encouraged to make their professional skills available to these people. However, it is not enough to be prepared for an occasional domiciliary visit carrying a bag packed with every tool from forceps to facebow. It is necessary to participate in the organisation of dental care not only for the affluent elderly but also for the indigent who are confined to house or institution, so that their appetites may be restored and their appearance blossom again. Such a spark has appeared in several communities, but occasional efforts are not enough and a sustained development is required.

The seven chapters of this book fall into two parts. In the first four chapters an attempt is made to introduce the reader to matters inherently related to ageing – from those affecting the psyche to those that concern the teeth specifically, the soft tissues of the mouth and, finally, to those considerations of nutrition and metabolism without a knowledge of which any attempts at treatment or management are likely to be empirical. Following these theoretical observations, the second half of the book is devoted to treatment of the patient, of his teeth and of the edentulous state. We hope that any repetition of the need for respect and concern will be condoned, for this recurrent theme is indeed the most important single message that our authors have to offer; we recognise, but reject, the view that compassion consumes time and that in present circumstances it has to be regarded as a luxury. It is, in fact, a genuine need.

One of the difficulties in dealing with elderly patients is that they may be frustrated by a lack of ability to describe what is wrong. The dentist has, therefore, to be skilled in transposing what the patient describes into a diagnosis. He must also be alert to the possibility that his patient may shrink from articulating unspoken fears so that an apparently unsubstantiated complaint about a denture could conceal anxiety about the tissues on which it rests.

There are omissions from the text but reasons for them. The tissues of the periodontium are discussed, but the prevention and treatment of periodontal diseases should be undertaken in middle age and earlier. Periodontal lesions are likely to have deteriorated too far for anything more than minor local palliative treatment in the seventies and eighties. The teeth may even have stabilised and will respond to measures such as simple mouthwashes and gingival packs for occasional pain or swelling. It is never too late for hygiene by tape, woodstick or cotton bandage, nor would it be wrong to perform minor occlusal adjustments to prevent the drift of a migrating tooth. The message must be to treat the periodontia of affected teeth in the forties and before with a view to preparing them to survive until old age.

Maxillofacial surgery and associated prostheses are not considered because they belong properly in a more specialised text. Likewise the treatment and after-care required for malignant disease is outside the province of this book, although it has to be emphasised that the dental practitioner has a crucial responsibility for the early recognition of these life-threatening conditions.

The diagnosis and treatment of systemic emergencies and those that may occur during dental operations are omitted because they are well described in such publications as 'Emergencies in Dental Practice' prepared by the Department of Health. This should be read and be to hand in every dental practice, department and domiciliary kit. In it there are appendices on drugs that may precipitate emergencies and on criteria for safety in dental anaesthesia, which receives only passing mention in our text.

It goes without saying that cooperation with the elderly patient's physician is essential and it is the dentist's responsibility to renew and maintain this contact. Finally, it is worth emphasising that short-term attitudes and treatment plans should be avoided for all elderly patients and not merely those who are

reluctant to accept the prospect of old age. They need all the encouragement they can receive in order to make the best of their remaining years. The dentist is faced with frequent complaints from elderly patients, many of them seemingly unjustified, but argument and anger are futile. Criticism must be absorbed and every effort made to help. Somehow these elderly nuisances must become old dears.

BC
HT

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Section I

Chapter 1

Understanding Older Patients

H. M. BRAMLEY

INTRODUCTION

The mention of elderly patients may bring to mind a classic stereotype: unsteady, stiff, slow, not seeing or hearing too well, muddled, fearful, having difficulty in remembering instructions and, what's more, about to cause an irredeemable delay in the day's appointments.

The physiological processes of ageing and the gradual diminution in acuity of the five senses are facts, but the rate at which they occur shows great variation. Some people assume the life of a cabbage and sink into presenile dementia in their fifties, while others maintain the creativity of a Verdi or a Churchill to the end of a long life. Nearer to our time and subject, Winifred Rushforth, in her 97th year, produced a new and significant work on the effect of the unconscious in everyday life.

Unique personality traits tend to become accentuated with age rather than diminished, and the occurrence of marked variations in physical capacity between persons and between bodily systems in the same person make sweeping statements about the elderly and our relationship with them quite untenable. There are only three generalisations worth making: we are born, we die, and in the intervening period we are all different.

Who are the elderly? Perhaps they are persons ten to fifteen years older than the dentist himself. Much of what will be said about understanding older patients applies to any age, but perhaps with the elderly even greater sensitivity is required.

The subject will not be presented in terms of formal psychology, but by illustrations from everyday practice. To aid discussion, the following three headings will be used: attitude of the dentist; the needs and features of older patients; and face-to-face.

THE ATTITUDE OF THE DENTIST

The establishment of helpful relationships between a dentist and his patient is a double-sided process. He must seek not only to

understand the patient but to be aware of his own temperament, and also to understand his own feelings, memories and prejudices as they are evoked by the clinical encounter.

Prejudices and anxieties

A difficult old person may remind the dentist of a cantankerous parent who has caused him much trouble and anxiety. The bad feelings so raised may interfere with his treatment.

A patient smelling of alcohol may sit down in the chair, arousing great anxieties in the dentist who has had to suffer an alcoholic spouse or parent. He feels his hackles rise, instead of wanting to understand his patient's difficulties.

Some professional men and women become excessively anxious when criticised. The older patient who says, 'Your treatment has made me worse; I can hardly eat at all now,' may be arousing feelings that the dentist had as a child, being continually criticised by perfectionist parents. Unless hostile feelings are recognised, thought about and understood, the dentist will act on them and emit hostile feelings to the patient. No good work can then be done between them.

Unacknowledged racial prejudice in the clinician, particularly if this is combined with language difficulties experienced by the elderly immigrant, is a recipe for uncaring management.

An overt homosexual can arouse fear or disgust in a dentist who has never really faced up to his own attitudes to homosexuality.

Male and female patients, even when old, can exert their sexuality and can take away professional confidence if the dentist is not quickly aware of what is happening.

> An attractive woman of 63 years of age, in accepting a compliment on her appearance from her much younger dentist, started to tell him in some detail how her husband was always chasing her and how she managed to keep him off except for once a week. The dentist was just about to adjust the chair to a reclining position and put his arm round her head for a dental examination. He was thrown off his professional stance by this confiding and seductive woman.

> A well-preserved elderly man looked into the eyes of his lady dentist and said, 'Do you believe in morals?' Such a remark must be accepted calmly, put in its place and a professional relationship restored, if effective work is to be accomplished.

From time to time, most dentists treat patients suffering from terminal illness. They may be giving the considerable service of achieving mouth comfort or perhaps, as oral surgeons, being concerned with more specialised issues. Some thought should be given to attitudes to death and the dying. Professional people are notoriously bad at facing up to this, and patients and their families often suffer in the web of dishonesty and deception which ultimately springs from the doctor's ignorance of his own emotional preoccupations. Tears, sadness, despair and the inability to cope with 'failure' all encourage him to avoid the truth. He should understand why he is particularly vulnerable and come to terms with the origins within himself, so that he can be straightforwardly supportive to such patients without deceit or anxiety.

Temperament

It is unlikely that any of us has an ideal temperament for dealing with each and every elderly patient. We can, however, be aware of our temperament and know that briskness and ultra-efficiency may be confusing and that gentle, warm optimism is to be preferred to glum frigidity; that physical closeness – the handshake, the hand on the shoulder – is to be preferred to polite formality and distance.

Cheerfulness is to be preferred to the jokiness which can be misinterpreted even though expressed with the best of motives, namely, to relieve tension.

> 'I'm sure I don't know what we're going to do with this odd mouth full of teeth.' The result of this light-hearted remark was that the patient, a retired Inspector of Education, became very anxious that something was seriously wrong and didn't like to ask the dentist. This worried her so much that a few years later she recorded this as one of the worst days in her life!

Each of us is stuck with our own particular temperament, but we should recognise and seek to modify the inappropriate impact of this temperament on elderly patients.

Attitudes to time

Time is money. Are we willing to bear the financial burden of unhurried consultation? Can we make the patient feel we are relaxed enough to listen to and fully understand his difficulties?

Can we regard one of our skills as listening and thinking about the total material the patient presents to us and produce a treatment plan which is entirely appropriate to that individual?

> A young dentist being interviewed about the job he was doing with geriatric patients said that he was very dissatisfied. He had been highly trained to do a skilled job and didn't feel he should waste valuable time listening to old people's endless complaints!

If dentistry does not take place in the context of a good, caring relationship, the amount accomplished will actually be less and it is certain that the patient will not be satisfied.

Personal security and avoidance of 'problem-solving' platitudes

Can the dentist be secure enough to be puzzled by a situation, to accept it and not to try to get by with remarks such as, 'Never mind, Mrs Smith; there's no need to worry; we'll soon have this sorted out'? This sometimes reassures the dentist but can make the patient feel that it is unacceptable to mention his real anxieties. It may be that the problem is insoluble and the dentist's most constructive approach is to share and bear the pain with the patient, who is thus given courage to face his problems and carry on. It is not easy to share pain, uncertainty and difficult problems with a patient, and the temptation to come to some unreal or untrue solution must be resisted. This is particularly so with pain and paraesthesia in the distribution of the trigeminal nerve, and with other more bizarre intraoral symptoms that resist all attempts, even at an advanced level, to make a diagnosis.

The dentist may well feel driven to resort to active treatment, which can lead to iatrogenic effects and ever more desperate measures, often with a resulting cascade of disaster.

Coming to terms with his own ageing process

The practising dentist's capacity for sustained and complex clinical work diminishes with age. If this is not recognised, standards will fall. To some extent this can be overcome by careful appointment scheduling, placing the more demanding work at the time of day when he is at his best and allowing ample time for its completion.

The dentist must be aware that a diminution of physical

capacity can subtly influence the quality of treatment planning. Age and experience often bring a more conservative attitude to surgical or dental treatment, and the complex and the ambitious may be set aside in favour of the basic and simple. This 'mature' judgement may, however, be a rationalisation of fading powers and not necessarily in the best interests of the patient.

The older dentist often has useful insights into the management of his elderly patients, but sometimes he will project on to these patients the very things from which he himself suffers, such as increasing indecision, deafness and forgetfulness, without acknowledging that he shares these deficiencies.

> A widow, aged 72, made elaborate arrangements with her daughter to be taken to the dentist for 9.15 a.m. only to be told that her appointment was at 2.15 p.m. although the morning appointment had been written in her diary. This was the dentist's mistake but, rather than admit it, he told her she must have heard wrongly. This was not the first mistake he had made with appointments. Instead of acknowledging his own forgetfulness and partial deafness and leaving all the appointment-making to his receptionist, he continued to make such mistakes.

NEEDS AND FEATURES OF OLDER PATIENTS

Rigid attitudes and painful memories

The patient's ideas of dentistry may have been inculcated in youth and never revised. Extractions and dentures may be his idea of the only functions of the dentist. His first contact with a dentist may have been painful, and it may be very difficult to persuade him that dental procedures need not be painful. His ideas and visions of any dental procedure may be completely different from those of the dentist and from reality. The dentist will never know this unless he listens. Reassurance is useless unless the patient's attitudes and fears are understood and he is confident that the dentist has understood them.

The fact that dental care may have benefits for health and happiness may not be appreciated until much unhurried time has been spent with the patient. Defences against fear and pain and the changing of long-held attitudes tend to grow stronger with age.