Patients' Perceptions of Dehumanization of Patients in Dental School Settings: Implications for Clinic Management and Curriculum Planning

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Abstract: Although the importance of empathy, rapport, and anxiety/pain awareness in dentist-patient relations has been well documented, these factors continue to be an issue with patients in many dental school clinics. The aim of this study was to develop an in-depth understanding of how patients at an urban, university-affiliated medical center and its dental school's clinic experienced oral health care and to generate ideas for improving the dental school's clinical curriculum and management of the clinic. Although patient satisfaction surveys are common, in-depth patient narratives are an underutilized resource for improving dental education. In-depth qualitative interviews were conducted with 20 uninsured or underinsured dental patients at these sites, and the results were analyzed using content analysis. Major phenomena that participants discussed were the importance of empathy and good rapport with their oral health providers and provider awareness of dental pain and anxiety. Many patients also discussed feeling dehumanized during dental visits. Based on their positive and negative experiences, the participants made suggestions for how oral health professionals can successfully engage patients in treatment.

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Behavioral science curricula in dental schools have focused on the importance of empathic communication skills for several decades.[1,2] These skills include active listening, providing appropriate empathy, responding to non-verbal behavior, and respectfully encouraging healthy behavior change.[3] When patients evaluate dentists, they are looking for providers who ask about pain and anxiety and are generally sensitive in their demeanor.[4-7] In recent years, there has been a growing awareness that behavioral training in dental school should also include sessions focused on communication with ethnic and racial minorities and with underserved populations.[2,8,9] Because oral health disparities exist for tooth decay, periodontal disease, and oral cancer and are influenced by ethnicity and socioeconomic status, it is important to teach students how to inter-act sensitively with underserved patients in order to improve their oral health status.[9] Overall, dental providers who are willing to explore the individual and environmental factors that influence a patient's oral health care utilization are more likely to engage underserved patients in care.[10]

Patient satisfaction surveys are the most commonly used method to understand the experiences of patients in large health care settings, including dental school clinics. However, one drawback of surveys is that they do not provide a detailed, nuanced view of a particular health care encounter.[11] First-hand patient narratives are also a valuable tool to understand the patient experience in order to improve dental school curricula and clinic management. These narratives may provide perspectives on patients' attitudes, behaviors, and experiences that are not captured by

other methods.[12] For example, when Wener et al. used patient focus groups to develop a measure of communication assessment for dental students, they found that patients emphasized slightly different variables than students and instructors, including the importance of provider pain awareness and holistic patient care.[13] Other efforts have included using standardized patients, whose mock histories are similar to that of the actors playing them, to teach students about cultural competence, including being sensitive to alternate ways of health and access to care issues.[14,15] A systematic review of patient-centered care in dental settings concluded that patients' perspectives on care have not been adequately integrated into patient-centered initiatives.[16] The aim of this qualitative study was to develop an in-depth understanding of how patients at an urban, university-affiliated medical center experienced dental care and to generate patient-driven suggestions for curriculum planning and clinic management.

Methods

This project was approved by the University of Illinois at Chicago Institutional Review Board (IRB) (Protocol #2011-0881). Participants were told that they could stop the interview at any time or refuse to answer any question without penalty; that their participation did not influence their ability to receive health care at the university clinics; and that the interviews were confidential and no identifying information would be used in the analysis and publication of the results. Participants agreed that interviews would be audiotaped for later transcription.

The University of Illinois at Chicago health sciences campus is located on the near west side of Chicago. The campus clinics serve patients who are largely uninsured or underinsured. Approximately 40% of the patients receiving dental care at the University of Illinois at Chicago College of Dentistry are on public aid, and almost all of the others are self-paying patients. Only 6% have private dental insurance. A substantial proportion (14%) of these patients are unemployed. Three women are served for every two men. Many patients are underserved ethnic minorities, with a patient population that is 25% Hispanic and 25% African American.

Based on the guidelines suggested by Kvale for conducting qualitative interview studies, our target sample size was 20 patients to achieve data saturation.[17] We recruited the 20 patients using two

methods. First, as part of a larger study on experiences in the health care system, patients in the waiting room at the University of Illinois at Chicago dental and family medicine outpatient clinics were given an optional locator form to fill out if they wanted to be contacted about future in-depth interviews. Patients who agreed to follow-up interviews were contacted by phone to schedule the interview. Second, IRB-approved fliers were posted around the medical campus to invite patients to discuss their experiences in the health care system. Patients interested in being interviewed contacted our study staff.

All interviews took place in a private office with the principal investigator (PI), a behavioral scientist with expertise in health psychology. Interviews took 45 minutes to one hour. All participants received a $20 grocery store gift card to compensate them for their time. The interview was semistructured. Open-ended questions focused on where participants obtained their health care and if they went to the doctor and dentist regularly. Participants were also asked to reflect on their most positive or negative dental visits. The interviewer probed for details about what—aside from the actual oral health diagnosis—made specific encounters positive or negative.

The research team, consisting of the PI and four research assistants, analyzed the interviews using content analysis, as outlined in Hancock et al.[18] The coding scheme was created using an iterative process, with the team reading through transcripts, creating themes, reaching consensus, and revising themes as more interviews were analyzed. Based on group discussion and eventually group consensus, the coding scheme was divided into major and minor categories. The team did not feel that the common emerging themes differed for men and women or among ethnic groups. As such, we retained all 20 interviews for analysis.

Once the coding scheme was created, the data were loaded into Atlas.ti for formal coding. Each interview was coded by two team members. Discrepancies that arose in coding were discussed in team meetings and resolved by group discussion. Finally, we examined the final categories for larger phenomena.[19] Overall, we used both deductive and inductive methods in our analysis.[20] The interview questions were based on prior knowledge of patient-provider behavior, and we expected that patients would mention issues such as empathy, rapport, and anxiety management when discussing positive and negative dental experiences. However, the specific categories

and larger phenomena that emerged from these interviews followed from an inductive process, meaning the research team read the interviews without any preset coding scheme. The themes of empathy and rapport emerged quickly; however, a strong theme of dehumanization emerged after further team discussion and in-depth examination of the transcripts.

Results

The 20 participants ranged in age from 21 to 74 years of age (M=49.8 years); 18 were female and two were male. Among these participants, 45% were white/Caucasian, 30% were Hispanic, and 25% were African American/black. All participants spoke English.

The major phenomena that the participants discussed were the importance of 1) empathy and good rapport with their providers and 2) provider awareness of dental pain and anxiety. Based on positive and negative experiences with providers, the participants had specific suggestions for how oral health professionals could address these issues successfully. Although we did not probe for this directly, some participants also reported a sense of dehumanization and a lack of cultural understanding in the oral health settings. The themes were remarkably robust across ethnic groups in this sample. Figure 1 summarizes the relationship among themes that emerged from the interview data.

Empathy and Rapport

The first major theme that emerged was the importance of empathy and rapport in the patient-dentist relationship. Many patients had suggestions about how dentists can establish a caring, long-term relationship with their patients. A 26-year-old white female suggested "getting to know you a little bit, but not being too intrusive. . . . being personable and joking and being funny and friendly." A 46-year-old white male commented, "It's not a revolving door thing like, 'Okay, you've got this, take this,' boom get out. . . . Talk to them, find out what is going on. . . . If they are having problems with pain, it may not be all the pain, it may be something else or maybe a hidden symptom with that pain. But if you don't find out what that symptom is, you are not going to cure the pain."

Some participants encouraged dentists to consider other medical issues patients may be experiencing and how that may influence their oral health treatment. "I want them to . . . look at my chart and see [she] has asthma, bronchitis. She can't come out in this cold. She can't come out when the temperature
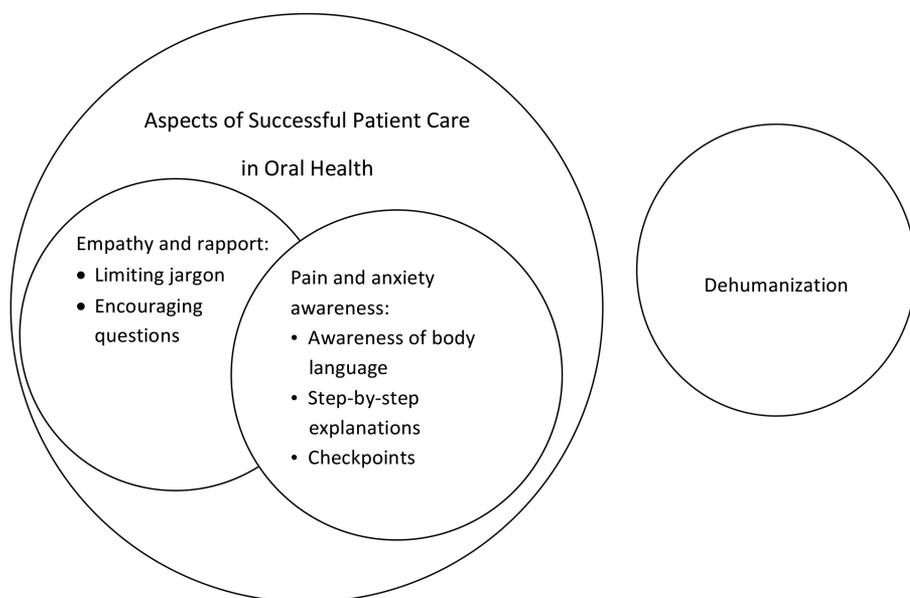

Figure 1. Relationship among themes that emerged from patient interviews

is 100, you know, 102 index," stated a 55-year-old Hispanic female. "They can be more people-friendly by looking at people's charts and seeing what's really wrong with that person . . . but they just overlook it." Similarly, a 62-year-old white female emphasized the need for "compassion," noting that "a lot of folks are walking with walkers, canes. If they're lying in a dentistry chair, it's not very comfortable all the time. Movement, maybe when they're having a procedure done, stopping for a while, letting the person get up or walk it up, to walk around."

Within the larger theme of empathy and rapport, participants had many specific suggestions about how a good therapeutic relationship could be established with their dentists. The participants noted feeling that dentists should limit the use of technical jargon and encourage patient questions and that these communication techniques were essential to developing patient-provider rapport. A 41-year-old white female emphasized her awareness that, by using lay language, the power differential between dentist and patient was less apparent: "Even if you do it [explain] that way then you're already putting yourself on the same level as the person." The interviewees also underscored the importance of providers' asking open-ended questions and discussing confidentiality. "[When] people know and hear that everything is going to be confidential, then they feel a little . . . less wary and scared" about what the dentist is doing, noted a 31-year-old African American female. "Dentists should ask them questions, more questions."

Awareness of Pain and Anxiety

The second major theme that emerged was the patients' belief that oral health providers must have an awareness of dental pain and anxiety and have skills to be able to manage these issues. The experience of dental anxiety was very common. As a 50-year-old African American female explained, "I'll go to the doctor; but the dentist! Back in the day . . . when you look up, the needle looks like it's twelve inches long. And it feels like the needle is going through your mouth, up into your brain. . . . To hear the sound of that drill, it was so scary to me. I don't see how anybody can go to the dentist."

Many participants mentioned prior traumatic experiences and how those may have influenced dental anxiety. "When I was young, he [the dentist] did some things and he accidentally took the scraping tool and jammed inside my throat," remembered a 46-year-old white male. A 26-year-old white female commented, "I've known women who have not gone to the dentist for years because just the idea of having someone touching their mouth . . . reminds them of the trauma that they've experienced. And a lot of times that's adult abuse. But it's more often from child sexual abuse." Similarly, a 55-year-old Hispanic female noted that "sometimes kids that were in foster care . . . like [me] have, and we talked about, sexual abuse. . . . Sometimes people talk about that dental care is really difficult for them."

The major suggestions these patients made for reducing dental anxiety involved patient-provider collaboration. Some participants underscored the importance of body language in reducing anxiety and pain, as when a 63-year-old African American female said, "That would be great for a dentist to ask, 'Do you have a problem with people touching you?' As a matter of fact, all doctors could ask you that." Participants also felt that dentists should check in with patients often, particularly during longer procedures. A 31-year-old African American female explained, "You're going to say, 'Okay. Now I'm going in with the syringe. I'm going to pinch your gum just a little bit. It may hurt just a pinch. But it will be really quick.' . . . It's like a psychologist . . . your patient has a phobia. And you try to figure out ways to get them to overcome their fear."

When reflecting on negative aspects of care, many participants reported a sense of dehumanization that resulted from not feeling listened to, cared for, or seen as an entire human being in oral health settings. In the process of dehumanization, patients may feel their needs are somehow secondary or unimportant. In the words of a 59-year-old African American female, "I think that there are a lot of preconceptions. My preconception about you really dictates the way I'm going to talk to you. The kind of care you're going to get. The kind of questions I'm going to ask you. Things I'm not going to ask you. I feel that that is very prevalent, much more so than we probably even realize, and it's not just race; it's class as well." A 74-year-old white male summarized the desire to be seen as a whole human being: "Doctors have to understand . . . be willing to climb into that world a little bit by people talking to them from the community, by going into the community. . . . I think you learn so much from that."

Many participants reported that finances were their major barrier in receiving regular dental care. A 39-year-old Caucasian female explained, "We've been going through some hard financial times. And

there is no good dental coverage or anything like that. I loved my dentist. My kids go every six months, but I have [not gone] for the last two years." However, some reported feeling that money was more important to providers than patients' health, an issue that dovetailed with perceptions of being dehumanized. As a 55-year-old Hispanic female noted, "It's more like a clout thing. Like I have . . . power over you and you're stupid. You used to have a moral code that you have on your door, you know, that you're here to help patients. . . . Now everything is about money. So if you have your mind on money, there's not much attention you're giving that patient." A 65-year-old white female commented, "Every private dentist I had that told me, 'It's going to cost you $10,000, go and get a loan,' I felt like that dentist pretty much stuck me up with a gun. . . . They will see me as one of a thousand: 'give-me,' begging, 'please help me.' . . . I'm taking care of my teeth and I've spent thousands of dollars on my teeth, almost $100,000 in my lifetime. . . . And I'm going to be just looked at as a number."

Discussion

In general, our in-depth interviews were highly consistent with prior studies on the importance of empathy, rapport, and pain and anxiety awareness in oral health care.[21,22] Our participants also brought up one overarching theme that we did not ask about directly in the semistructured interviews. Some described feeling dehumanized when they were not treated with respect, when they felt they were judged based on whether they could pay or their socioeconomic status or race/ethnicity. Unfortunately, this is an issue that deserves more attention in dental school curricula and clinic management.

Regarding curricula, this study underscores the importance of discussing dehumanization in oral health care, a topic not always addressed directly in coursework. It may be particularly difficult for dental students to discuss financial hardships with patients in a way that is respectful. Unfortunately, relating to the struggles of patients does not necessarily increase with clinical contact. Sherman and Cramer found that first-year dental students scored highly on measures of empathy, but that empathy declined as students began patient care.[21] Haque and Waytz reported that dissimilarities (e.g., ethnicity, socioeconomic status) between patients and providers can encourage dehumanization in medical settings, but they argued that dehumanization can be functional at times because providers must control their empathy in order to provide care.[22] These researchers recommended that training focus on ways to promote the humanization of patients (e.g., eliciting background information in addition to the presenting problem) and give providers skills to discern when empathy is useful (e.g., in routine outpatient visits) and when it should be put aside (e.g., during surgical procedures that may cause pain).

Currently, communication skills in dental schools are often taught with review of videotapes of dentist-patient interactions and simulated encounters using standardized patients.[23] Indeed, multiple sessions over a four-year curriculum, incorporating instructor coaching and standardized patient interactions with feedback, have been found to be one way to increase student empathy and decrease dehumanization of patients.[24] However, because standardized patient pools may not represent the demographics of the patient population, patient narratives or videos may also encourage increased empathy for underserved populations.[25] In addition, many dental schools are utilizing community-based education to teach the next generation of oral health providers. Working in underserved communities allows students to gain extremely important perspectives on the barriers and strengths of community residents, particularly when students are encouraged to provide written reflections on specific clinical interactions.[26,27]

The findings of our study are consistent with research on student perceptions and patient complaints and may also have implications for clinic management in dental school settings. For example, in a study of dental students in North America, many students worried that dental education requirements made it difficult to prioritize the patient's needs.[28] In that study, some students felt that procedures were done for the sake of requirements, without looking at the patient holistically. A potential strategy to better engage patients in treatment is to assign them to student teams rather than an individual student.[29] Such a system allows fourth-year students to complete more difficult procedures and ensures that third-year students are involved in treating the patient and patients do not have to repeat their personal history again from year to year. In addition to a team-based approach, increasing the diversity of dental faculty members may provide students with more viewpoints on how cultural and socioeconomic factors can interact with experiences in oral health care.[9]

Finally, patient satisfaction surveys can be a useful teaching tool, both for individual providers and health care systems.[24] Our findings suggest it is important for clinic satisfaction surveys to include general measures of dentists' communication skills and specific questions about sensitivity toward pain and anxiety. Clinic surveys should also include questions about dehumanization, such as patients' feeling of being seen only as a set of symptoms or experiences with prejudice based on race or socioeconomic status.

One possible study limitation was selection bias because participants had to be conversant in English and comfortable with a one-on-one interview format. Volunteer bias may have also influenced our results because participants with highly negative experiences in health care may have been the most likely to volunteer for our interview. Finally, because our participants were recruited in one academic medical center, they are not representative of all populations of underserved patients, for example, those in rural settings. Although our sample was ethnically diverse, it was largely female, suggesting it is important to further understand male perspectives on this topic. Thus, future samples should include participants with heterogeneous experiences and from varied settings.

Conclusion

In this study, the 20 patients interviewed reported that empathy and rapport were essential components of successful oral health care. They felt rapport could be established by explaining things to patients using non-technical language and getting to know the patient as person. These patients felt dentists' awareness of patients' pain and anxiety was important and emphasized the need for behavioral techniques, such as being aware of body language, explaining procedures to patients ahead of time, and allowing patients to begin with simpler treatments. The theme of dehumanization also emerged in our analysis and was related to being seen only in terms of a diagnosis. This theme was closely tied to financial difficulties, minority status, and an inability to pay for optimal treatment. Our findings suggest that patients' perspectives, particularly the narratives of those from underserved populations, can validate educational goals, help refine curricula, and provide guidance for clinic management in dental education settings. The results of this qualitative study support

the idea that the patient-provider relationship is an extremely important part of engaging patients in oral health care, but suggest that the issue of dehumanization needs to be addressed in dental education.

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