The need to overcome barriers to dental care for older people of ethnic minority groups

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Introduction

- In an increasingly diverse 21st century Britain, we are all part of a multi-ethnic, multi-racial and multi-faith society. We are also part of a rapidly ageing society, where Black and Ethnic Minority populations are progressively ageing alongside the White British population.[1]
- However, the older population, particularly those with physical and mental health conditions, have been described as being a marginalised group. Being of a Black or Ethnic Minority population may further compound this marginalisation.[2]
- The current COVID-19 pandemic has harshly exposed some of the health and wider inequalities that persist in our society.[3] As members of the dental profession, we have a moral duty to deliver optimal care to all patients.
- The author presents a case report, summarising the provision of dental care to three older patients of a Somali heritage. This highlights the need to recognise important issues and barriers that older people of Black and Ethnic Minority groups might face, which could affect access to dental care.

Case Report

Medical History

- **Patient 1:** Parkinson's disease, dementia, wheelchair dependence for mobility, non-verbal but can sometimes respond via nodding and crossing the head.
- **Patient 2:** Dementia, depression, wheelchair dependence for mobility, non-verbal, distressed and confused demeanour, unable to communicate.
- **Patient 3:** Depression, bipolar disorder, under psychiatric outpatient care, arthritis, glaucoma, can occasionally communicate verbally through the Somali language.

Social History

- **Patient 1:** Lives with older wife and nine adult children; attends dental visits with children, and sometimes his wife; can transfer to the dental chair with help from his children; understands English.
- **Patient 2:** Lives with adult daughter who is her main carer; also supported by a paid carer; attends dental visits with daughter and carer; unwilling and unable to transfer into the dental chair.
- **Patient 3:** Lives with older husband and adult son who are her main carers; attends dental visits with husband and son; son provides interpretation and translation.

Patient 1:
65 years of age, male
Patient 2:
87 years of age, female
Patient 3:
61 years of age, female

Dental History

- **Patient 1:** Referred to the Adult Special Care Dentistry service by his general dental practitioner (GDP) due his medically compromised status; last saw the GDP six months ago for an exam; irregular attender otherwise; GDP is unsure if the patient has dental pain; patient's children feel that he has dental pain due to a change in his behaviour.
- **Patient 2:** Referred to the Adult Special Care Dentistry service by her GDP, as the patient cannot be examined; irregular attender – last had a thorough exam many years ago; daughter and carer inform that the patient often clasps the right side of her face in pain, and that she has been drooling due to the dental pain.
- **Patient 3:** Referred urgently to our Specialist Endodontic service by her GDP for endodontic treatment of the UL6 due to immense pain; irregular attender; the specialist endodontist subsequently sees the patient and deems that it is the UL7, which has the problem, and that the UL7 is unrestorable and requires extraction; the specialist endodontist refers the patient to the author for an urgent extraction of the UL7.

Examination

- **Patient 1:**
-Presenting complaint: sons' report that the patient has dental pain but unsure where this could be; the patient cannot communicate this.
-Extra-orally: no abnormalities detected (NAD).
-Intra-oral soft tissues: NAD
-Intra-oral hard tissues: shortened dental arches with lower 8s, LR7 and UL6 present; moderately restored dentition (posterior teeth restored); UR2, UL5 and LR5 restored with crowns; LL8 heavily restored with amalgam; generalised moderate attrition; generalised moderate abrasion; generalised mild fluorosis.
-Caries: UL4 grossly carious retained root (RR) in situ - this was tender to percussion (TTP), which made the patient shudder; LR4 distal caries which was asymptomatic.
-Gingivae: generalised moderate recession; generalised plaque and bleeding on probing.
-Periodontal considerations: UL1 and UR1 grade 1 mobile. Generalised probing depths of 6mm.
-Oral hygiene (OH) status: generalised plaque and food debris present; signs of suboptimal OH.
-OH habits: sons' help to brush the patient's teeth, twice a day, with a manual toothbrush and fluoride toothpaste
-Radiography: Attempted to take bilateral horizontal bitewing radiographs; however, the patient could not bite down upon instruction, despite lots of encouragement. Instead, an orthopantomogram (OPG) was taken.
-Radiographic findings: The OPG showed: carious UL4 RR with associated periapical radiolucency; root-filled UL5 with associated periapical radiolucency; heavily restored UR4 with amalgam, close to the pulp with a questionable periapical radiolucent area; generalised moderate horizontal bone loss; grade 2 radiograph, as the anterior region was slightly lighter in appearance.

- **Patient 2:**
-Presenting complaint: daughter and carer report that the patient has dental pain in the upper right region, which disturbs eating ability, causes drooling, and has led to the patient often screaming in agony.
-Extra-orally: NAD
-Limitations: the patient was confused and distressed; she refused to be transferred into the dental chair, when her daughter attempted to move her, thus, an exam was attempted with the patient seated in the wheelchair; a quick, limited examination was only possible.
-Identifying the problem issue: the author managed to locate and observe the problem – grossly carious and broken UR7; deemed unrestorable with a hopeless prognosis.
-OH status: Fair; minor plaque deposits present; generalised extrinsic staining, possibly due to foodstuffs, tea or similar.
-OH habits: daughter or carer brush the patient's teeth twice a day, with a manual toothbrush and fluoride toothpaste.
-Radiography: Unable to pursue due to noncompliance.

- **Patient 3:**
-Presenting complaint: son reports that the patient experiences intense pain from the upper left region; son warns not to do too much, as the patient will get agitated, fearful and restless; son requests that only the problematic tooth should be extracted, as the patient will be unable to cope.
-Extra-orally: NAD
-Intra-oral soft tissues: NAD
-Intra-oral hard tissues: large subgingival disto-occlusal (DO) carious cavity in UL7; extremely TTP; poor prognosis; upper and lower arches have 8-8.
-OH status: Fair; minor plaque deposits present
-OH habits: son or husband brush the patient's teeth twice a day, with a manual toothbrush and fluoride toothpaste.
-Radiography: periapical radiograph of the UL7 provided with the GDP referral; showed a large, subgingival carious DO cavity close to the pulp with a periapical radiolucency, and periodontal involvement.

Diagnoses

- **Patient 1:** LR4 D caries; endodontic failure of the UL5; chronic apical periodontitis of the UL5; grossly carious UL4 RR with hopeless prognosis; generalised chronic periodontitis.
- **Patient 2:** Grossly carious UR7 with hopeless prognosis; possible irreversible pulpitis of the UR7, or acute apical periodontitis of the UR7 due to the acute and intense described symptoms.
- **Patient 3:** UL7 DO deep subgingival caries; chronic apical periodontitis of the UL7 with periodontal involvement (combined perio-endo lesion).

Treatment Plan

- **Patient 1:** (i) Prevention– oral hygiene instruction (OHI) and dietary advice; (ii) Periodontal therapy – supra and subgingival debridement; (iii) Definitive – LR4 D caries removal and amalgam restoration; (iv) Stabilisation – extractions of UL4 and UL5 (planned for the end, as patient's children expressed that the patient is fearful of having extractions).
- **Patient 2:** (i) Stabilisation – referral to Hillingdon Hospital's oral and maxillofacial surgery for urgent extraction of UR7 under general anaesthesia (GA), as well as for a thorough dental exam under GA and/or any other necessary dental treatment under GA.
- **Patient 3:** (i) Stabilisation – extraction of the UL7 to remove active disease and eliminate pain; (ii) attend shortly thereafter for an examination to assess any additional treatment needs and to build rapport.

Appointments

- **Patient 1:** (i) Examination to determine treatment needs; (ii) prevention and periodontal therapy; (iii) prevention, periodontal therapy and LR4 D restoration – during this appointment, a buccal swelling adjacent to the UR4 was discernible, and a collective decision was made for this to be extracted, along with UL4 and UL5; (iv) extractions of the UR4, UL4 and UL5; however, this was rebooked and there was failure to attend.
- **Patient 2:** (i) Examination to determine treatment needs; (ii) three month recall to reassess treatment needs, oral hygiene status and build rapport.
- **Patient 3:** (i) Stabilisation – extraction of the UL7 to remove active disease and eliminate pain. To book a recall exam thereafter.

Challenges

- **Patient 1:** dependent on family members for communication and self-care; family declined the use of interpretation services; patient fearful of dental extractions- may have led to failing to attend this appointment; the author contacted the family to suggest a referral to Hillingdon Hospital's oral and maxillofacial surgery department for extractions of UR4, UL4 and UL5 under GA - the family were agreeable to this; the patient subsequently attended there for an initial consultation, and then for the extractions.
- **Patient 2:** dependent on her daughter and carer for communication; daughter declined interpretation services; patient was extremely confused and distressed - this precluded a thorough intra-oral exam; the dental exam was attempted, whilst the patient remained seated in her wheelchair, as she did not wish to leave from there; the only realistic option was for the patient to have a thorough exam, the UR7 extraction, and any other necessitating treatment performed under GA in a hospital setting.
- **Patient 3:** dependent on her son for communication; older husband cannot speak English; son and husband declined an interpretation service; son requested for only the extraction of the UL7 to be performed; the author had to quickly build trust and rapport with the patient and family in order to successfully extract the UL7; patient was fearful and distressed during the extraction, and required joint support and reassurance from the author, dental nurse, and family members.

Discussion

- This case report demonstrates similarities between the three patients: similar dental health problems, social histories, and treatment needs. Perhaps these patients face similar barriers to dental care.
- Due to the ongoing civil unrest in their home country, the number of Britain's Somali immigrants grows.[4] Therefore, it is important to understand this community's heritage, both cultural and religious, that they bring with them.
- Most Somali-heritage persons have a strong Muslim faith, and its principles inform much of their behaviour regarding their health, including dental care.[5]
- It has been reported that Western dental providers, may have not been mindful of these traditions, as they have attempted to instil Western practices into their Somali-heritage patients' oral health regimes.[6]
- Many older people from the Somali-heritage background use a stick brush, an 'aday' to clean their teeth; this is based on the Islamic practice of cleansing before prayer. Charcoal could also be used to clean the teeth. Many older people may be accustomed to traditional habits and customs.[7]
- The number of Somali immigrants who self-report their oral health as poor or fair is much greater than the general public at large.[8] This may indicate that proper OHI may not be reaching the Somali immigrant population, or it is not being understood correctly.
- As refined sugar is not typically found in the traditional Somali diet, cavities are thought to be rare in the home country. Many Somalis reported that their first ever cavities occurred after immigrating to the West, where they were introduced to a diet of more sugar-processed foods. Many Somalis have never even been to the dentist or even needed one.[9]
- Barriers to dental care for Somali-heritage patients can include a low level of health literacy, cultural needs, cultural traditions, and language issues. Many Somalis associate dentists with pain and with the removal of a tooth.[5,6]
- This stresses the need for improved access to oral healthcare and culturally appropriate oral health education and promotion programs.

Future Considerations

- Preconceived ideas, or previous experiences with GDPs, or in the hospital setting, if negative or different, may hinder future attendance, and may prevent acceptance of new ideas or practices.
- Good communication, compassion, more time, patience and adapting to the needs of such patients is extremely important.
- Further cognitive decline, owing to the worsening of these patients' mental health conditions, may require more care and dependence from family members, and possibly carers; this may place a considerable physical and emotional strain on the family members.
- Being able to offer or refer these family members to services where they can seek support and assistance will be useful.
- Implementing three month recall appointments to reinforce preventative principles, and strengthen rapport will be beneficial.
- The use of high fluoride toothpastes may be valuable.
- As a cultural tradition, older people of Somali heritage are typically cared for by their spouses, children and extended family members, thus, involving family members in prevention and oral care plans will be vital.
- Respecting wishes – family members wishing to provide interpretation and translation for older people; using interpretation services when deemed absolutely necessary.
- Improving oral health awareness in the younger generations of such minority ethnic groups may equip them with increased knowledge and skills, not only for themselves, but for when taking care of their older family members in the future.
- The author collaborated with the service's Dental Health Educator to deliver community initiatives. Networking within this, allowed a GDP, based in Hayes, to share their concerns about the high levels of dental disease within the local Somali and Pakistani communities. By collaborating with this GDP, an oral health awareness initiative was conducted at Hayes Town Mosque - the largest mosque in Hillingdon. Taking place during Friday prayers, the aim was to interact with as many worshippers as possible, and offer oral health and preventive advice, and dental tips, as well as answer anyone's dental queries. The event was well received, and the GDP requested further events. Such cultural awareness can build patient rapport and cooperation, thereby increasing patient adherence with treatment.[10]

Conclusion

- As Britain's population continues to age, and continues to become more diverse, we must do our level best to embrace diversity, and promote equality and inclusivity.
- Older populations, and especially those of black and ethnic minority groups can be marginalised; this may act as a barrier to certain older people receiving the optimal level of dental care that they require.
- The current COVID-19 pandemic, itself, is acting as a major barrier, and it is likely to be exacerbating existing barriers.
- Thus, we as dental professionals must learn more about our country's diverse ethnic groups; their cultures, traditions, and home countries, so that we can have a better awareness and understanding of the barriers that they might face; we must aim to implement strategies and initiatives, to help overcome obstacles for all people.

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