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Psycho-emotional Comfort of the Patient: Condition of Therapeutic Success in Outpatient Dento-Alveolar Surgery

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Abstract

Emotional stress appearing after dental care is the most destructive set of feelings, thoughts and images caused by pain. It is likely that "the easiest way to obtain a negative autonomous reaction is to visit a dentist or dento-alveolar surgeon". It does not require more than a short visit in the dentist's waiting room to "trigger" one's fear and anxiety. The study aims to develop a set of assessment criteria for the emotional profile of a patient who has to undergo the outpatient oral surgery. The goal of the clinical investigation of anxiety versus pain is to identify emotional reactions; it uses verbal and non-verbal methods of assessment, scales and questionnaires. Both the importance and the aim of behavioral assessment are used to provide reasonable surgery and anesthesia recommendations for the patient that would not exceed patient's functional reserves and prevent an unforeseen medical accident.

Keywords: psycho-emotional state, dental anxiety doctor-patient relationship, psycho-emotional approach, negative emotional stress, quality of life, dento-alveolar surgery

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Introduction

The diagnostic decision is unique and it justifies the decision on treatment through deduction and reasoning, the medical act involves the identification of problems and patient's specific needs, carrying out a correct and complete clinical exam and justifying the treatment plan. Surgeons always feel the need to act when they face a problem. Sometimes to know what and when not to do something is an art and we all need to learn it. We are tempted to use insufficiently tested or incomplete treatments out of desire to solve an apparently minor problem. Practitioners sometimes try to compensate lack of surgical experience and knowledge of patient's specific problems by using various surgical techniques, drugs and other surgical maneuvers by eluding the downplayed aspect of patient's benefit. Even if, according to the dictionary of Latin "Errare humanum est", each member of medical community has to be aware that by harm brought to the patient due to surgery, be it insignificant, such as outpatient dento-alveolar surgery, they bring prejudice to man's fundamental right – physical and moral life and integrity. Hippocrate's principle „primum non nocere" is still valid and should be respected (Astarastoae & Stoica 2000). This leads us to the scope of bioethics especially to its two main concerns: to do no harm (non maleficience) and to do well (beneficience) (Scripcaru, Astarastoae, & Scripcaru, 1994). There are multiple consequences, scars and failures of outpatient dento-alveolar surgery, their appearance having several reasons. The dento-alveolar surgeon should know the risks of the maneuvers he has to perform. The individual approach is the ground stone of success so that the assessment of the psycho-emotional state of the patient must be approached very seriously as its clinical implications are varied (Aldea & Aldea, 2001).

Insufficient knowledge of patient's history is one of the main factors of failure in the outpatient dento-alveolar surgery. In dentistry, patients who arrive at the practice general have limited knowledge that comes whether form prior personal experience or stories of other patients, close or distant relatives, friends, etc. (Chirita, Szalontay, & Iliescu, 2001). People who have benefited from positive, happy experiences, without incidents, accidents or unpleasant complications enter into the dental clinic calmly and cooperatively. To the contrary, patients with less positive personal experience or the experience of other people are as a rule more cautious, frightened, and stressed. The patient is mainly afraid of pain, pain being en experience that each person experiences more or less often, with higher or lower intensity (Cawson, 1991; Liau & Kok, 2008).

So, it is normal that a patient be concerned about the method, technique and quality of anesthesia and surgery, the chance of problems in the installation and length of anesthesia that may cause pain during surgery or immediately after it. The doctor-patient relationship from a psychological perspective has been more "cold" in the last decade and it seems that it has not been given proper attention,

the doctor being more concerned with the organic pain of the patient and not with patient's psycho-emotional state. Even if modern anesthesia procedures have greatly changed the working environment in dental practice or in outpatient oral and maxillofacial surgery, patients who have to go through dental care treatments still experience emotion, anxiety and fear (D'Eramo, Bontempi, & Howard, 2008; Howard, 2009; Feck & Goodchild, 2005; Pippi *et al.,* 2014). The issue of dento-alveolar surgical interventions in a dental practice show multiple aspects and needs in the context of increased dental care in private and state practice in Romania. A systemic vision on a clinical case is essential for understanding the specificity of a patient allowing the implementation of a multi-disciplinary approach adapted to patient's needs and requirements.

The proposal for any surgical treatment is usually received as an unknown, risky and definitely an unwanted event. Fear most of the times come from the unknown. The advancement of medical knowledge, successes of modern surgery have strengthened even more the old cult of people for medicine and those who are trained to relieve the pain and remove the disease. Without exaggerating this view, we believe that the doctor through his professional and moral presence should inspire total trust. Also, the patient also thinks of remaining alive. A patient who is administered loco-regional and general anesthesia or even a minor surgical operation will almost always keep (even if he does not recognize it) inside his soul a threat or even fear of losing his life. These general statements come to shape the idea that the patient's preparation, understanding and learning patient's behavior and his neuropsychic and organic reactions for any type of dental care our outpatient oral surgery needs attention and special consideration in terms of pre-anesthesia techniques.

Consequently, the aim of our study was to develop a set of assessment criteria assessment criteria for the emotional profile of a patient who had to undergo the outpatient oral surgery. Emotional stress that appears after a painful treatment is one of the most disturbing feelings in the flow of emotions, thoughts and images produced by pain. The issue of the vicious circle of pain refers to the fact that pain induces anxiety that in turn triggers muscle spasms in the area of pain location with vasoconstriction and production of pain-promoting substances. Therefore, a negative emotion is a good predictor of pain and also of the way in which the patient accepts both therapy, as well as its degree of success (Rotaru, Sirbu, & Campianu, 2001).

Methods for assessing the psycho-emotional state of the patient undergoing oral surgery

Outpatient surgery was defined as "simple surgery" which is traditionally carried out on a hospitalized patient and may be done as efficiently without hospitalization. The meaning of "outpatient" is that "patient is left with the possibility to move and continue his work". In the USA, over 60% of oral maxillofacial surgery is performed in outpatient context. The wish of modern dentistry, common to both practitioners of both general dentistry and oral surgery, is that "total dentistry in one day stay" or "Total surgery in one visit" should become reality also in our country not only through better methods and techniques of loco-regional anesthesia but also by conferring a wider applicability to alternative pre-anesthesia procedures.

For no other medical specialty, the issue of knowing the specificity of a patient and adapting therapy to his needs is as important as to surgery. The method of anesthesia, surgical intervention is an aggression, which in case it ignores the reactive, psychic and organic specificity of a patient may bring to patients more disadvantages than operative benefits. In clinical medicine, the practical importance of specificity appears especially when the reaction of a patient to a common aggression differs from known standard of a specific pathology. Medical-surgical medical history, general exam on devices, general biological exams have the role to detect deficiencies or functional or organic insufficiencies, sometimes latent and other times manifested but always to be considered. Numerous authors give big importance to the preliminary visit of the patient to the dentist in which the medical history is investigated, patient's general state is assessed and lastly his psycho-emotional profile is developed (McCarthy, 1998; Stiagalo, 2006).

Dental anxiety is mainly linked to a negativist behavior and it main source is pain and fear of pain, pain being an experience which every person experiences more or less often with higher or lower intensity. Moreover, highly anxious patients are most affected by pain. These patients show a behavior avoiding contact with a dentist or oral surgeon and usually the state of their health and oral hygiene is quite poor. They usually use dento-alveolar care only led by external factors: pain, suppurations, trauma (Sirbu & Rotaru, 2001; Peltier & Dower, 2006). Even if the patient is aware that his state of fear is not justified and is even irrational, he cannot do anything to control or eliminate it. An epidemiological study conducted by American Dental Association Council in 2003 reported that 18 % of US population avoids care of medical practitioners due to anxiety even if they had dental pain. Emotional stress that appears after dental care is the most distinctive aspect of the flow of emotions, thoughts and images caused by pain. Maybe "the easiest way to obtain an autonomous negative reaction is the visit to the dentist or to the dento-alveolar surgeon". One visit to the waiting room of a

dentist may trigger fear and anxiety (Hupp, Williams, & Vallerand, 1996). As a consequence to this reaction, especially if there is pain, the patient will avoid as much as possible contact with the dentist. Modern psycho-biological research has shown a varied degree of intensity and length of painful reactions depending on the degree of anxiety, this fact has a great importance in the addressability to dentists. Emotional stress that cannot be correctly controlled increases even more the experience of pain, decreases its threshold and changes tolerance to medication. Pain has definite anxious aspects affecting not only the patient but also his state (Granate, Voroneanu, & Earar, 2001).

The goal of the clinical investigation of anxiety versus pain is to identify emotional reactions with an impact on describing pain. Signaling function of pain is mainly reflected by the emotional side of this experience. In fact, the emotion accompanying pain shows a need causing immediate focus of resources on adapting to a threatening event. The most known "instruments" for global assessment of pain are the State-Trait Anxiety (STAI X_1, X_2) and Corah Scale and it is recommended for the analytical sample to use *pain anxiety symptoms* scale (PASS) that includes the STOOP sample. Out of these options described in literature, Corah Scale is recommended as the most known "instrument" in assessing patient's degree of anxiety towards dental treatment. (Brad, Bancila, & Lazarescu, 2001).

Behavioral exteriorisation of pain may be studied by an expert based on systematic observations that use specifically designed grids. Depending on the provided answers, an extremely important score is given for further surgical treatment. The one-dimensional methods of pain assessment include scales with visual descriptors, analogue visual scales, numeric scales, scales with behavioral anchors and imaging scales. In the standard version, the analogue visual scales comprise a ruler with a specific length (10, 20, 50 cm) oriented horizontally or vertically with the extremes bounded by two phrases: "no pain" and "most intense pain". The patient is asked to indicate on a scale the point that matches the degree of intensity of the pain he feels. The distance in centimeters from the end of to the set sign is the numeric indicator of pain intensity: (1) Numeric scales make the patient quantify pain using numeric values from 0 to 10 or 0 to100 (zero stands for no pain and 10 or 100 for the strongest pain); (2) Numeric scales have good validity, are easier to understands and use compared to scales with verbal descriptors scales or with behavioral anchors and imaging and aslo compared to analogue visual scales (Brad, Bancila, & Lazarescu, 2001; Granate, Voroneanu, & Earar, 2001).

Opportunity provided by being aware of patient's psycho-emotional state in conducting oral surgery

Dental anxiety is a serious problem both for the patient and for the dentist. Anxious patients have a tendency to avoid treatment and once found in the dentist's chair they are hard to control. Our mission as professional surgeons is at the end of intervention to gain a patient and not just solve a case. In dento-alveolar practice, it is very important to know patient's psychological state and what are his feelings towards his doctor and the therapy.

It is not easy to provide this apparently simple dental care, as theoretical, practical knowledge and skill should be complemented by interest in patients' feelings, emotional life, need for communication and affectivity etc. Our innate capacity to understand and to react instinctively is a clinician's priceless gift. A clinician acquires in time scientific knowledge about people and their personality, which enriches his natural understanding capability. We believe that in the overall natural care for a patient's comfort, for the success of a quality treatment that a "gifted" doctor displays should not be limited to anatomical, physiological, biochemical etc. knowledge, it should also extend to the psychological traits of each and any patient.

Psychologists launched the idea that "every patient should be seen as a whole and not as his component parts". When they say "whole", psychologists understand to regard a patient as a unique personality, with his own set of hopes, feelings and fears. During examination his parts should not be seen as existing and operating on their own, but as components of one whole being. This is why the doctor has to "memorize" the patient's personality. The attention paid, the mental grasping of what is the patient psychologically is the highest type of professional preoccupation (American Dental Association Council, 2003). If essential medical and/or surgical changes are required, the doctor's duty is to be supporting the patient in adapting to these changes. A new situation may be conducive to fear or anxiety, as it may threat the person, even though in reality there is no threat. It is not necessary for a dentist or/and dental surgeon to be psychologist or psychiatrist to identify some specific behavioral traits of the patients needing dental care or surgery.

Out of the multitude, variety and complexity of cases needing dental treatment, the doctor has to recognize a range of psychological personality types. The particular behavior of a patient shows quite precisely the personality type it belongs to. It is recommended that the clinician recognizes and identifies the psychological personalities displaying a well-structured behavior that he meets sometimes in his practice: verbal, impulsive, hysterical, paranoiac and schizoid personality (Berggren, Hakeberg, & Carlsson, 2000). The psychotherapy used by the dental surgeon provides a wide-range support for collaborating with some

psychological personality types. The first step in providing this support is to anticipate the anxiety and to be prepared for anxious expressions (Dima-Cozma & Cozma, 2012). A basic aspect of this therapy is how the doctor approaches the patient. If the doctor is friendly, warm, calm and relaxed, many of patient's perceptive distortions may be annulled or diminished. The practice environment is extremely important: good-looking furniture, warm colors, comfortable atmosphere, relaxing music in the background and a gentle nurse may put the patient in a comfortable position of collaboration. The dentist and/or dental surgeon helps a great deal if he gives enough time to build patient's trust, approaching him with a deliberate and skilful confidence. If the psychological state of a dental phobic turns favorable, the cooperation with the clinician comes naturally and goes on smoothly (Anderson, 2004).

One of clinician's basic preoccupations in preventing dental or oral pain, regardless of the loco-regional or general anesthesia, is for patient's psychological preparation. A vicious circle occurs with fear of pain and actual pain: fear leads to tension and adrenaline discharge, which is conducive to vasoconstriction that increases sensitivity to pain which induces a new state of tension (Tofoli & Ramacciato, 2007). Psychological preparation starts with the first appearance in the dental practice. Highly receptive to what is going on, the prospective patient will record all the events related to his visit, the order and professionalism in the practice, the welcoming or indifferent attitude of the staff. All the methods of humanizing the dental practice, the cleanliness, politeness, order and discipline are objectives of anticipated psychological preparation. Any incident or misunderstanding occurring during dental or surgical consultation will have a negative impact on the success of the therapy for that particular patient.

Patients coming for dental care or dental-alveolar care are generally speaking quite different. Some are brave and seem indifferent, some are extremely anxious and everything in between. In dentistry and out-patient dental surgery, more than in any other medical specialty, we are in full human interrelationship domain, which are of utmost importance as "the challenge in dental therapy or dental surgery comes not from the specific disorder, but from the temperament and emotional tension of patients" (Meechan, 2005).

Personal interrelationships are a two-way current and we take into consideration patient's attitude to the dentist and dentist's attitude to the patient. Sometimes it is difficult for a technically highly experimented practitioner to understand the disorder of the patient and cannot in a simple manner explain and inform the patient of the challenges that may appear. If such a practitioner is with a patient that is a difficult person, whose nervousness may be aggravated by irritability or pain, by prolonged waiting time, the impact between the two personalities may raise essential communications challenges even if the intervention is quite small. Such a case is however extreme on the scale of human interrelationships, as by mutual understanding, condescendence and affability

pathologies may be solved in a smooth and pleasant way (Abrahamson, Berggren, & Carlsson, 2000) An aspect that should not be overlooked is the fact that the anxious patient is at the border of syncope, a syncope that may be triggered by an insignificant pain caused by a simple injection or even a smell or noise created by instruments, causing thus real medical emergencies that may put in danger patient's life (another essential principle of bioethics is that of preserving patient's life), emergencies that require efficient quick measures.

A good understanding of aspects that should be performed at the practice as first representatives of the medical shield in the defense against the inevitable ensures the gain of precious seconds (Voroneanu *et al.,* 2007). Continuous training of practitioners doubled by experience gained in time is the premise for a careful medical attitude, especially in case of emergencies that help solve high risk cases.

Conclusions

As the importance of the impact generated by emotional stress has been recognized, several "instruments" were suggested to the clinician, all aimed to assess globally the anxiety using questionnaires or other analytical tools in order to process pain cognitively. In dental medicine, self-assessment, behavioral measurements, biological examinations monitoring the response of the body to pain are accepted as *"golden standard" of pain measurement.* We believe that if "the concept of preoperative psycho-emotional approach" would be adopted in outpatient dento-alveolar surgery, it would be a great achievement for practitioners that are directly responsible morally, financially and forensically for compromised interventions. A modern and complex attitude supported scientifically through clinical studies and results may provide to dentists and oral surgeons calm, cooperative patients with a feeling of comfort and safety and reduce to the limit possible risks. Experience enables us to state that the main cause of failure in dento-alveolar surgical treatment may be the patient with whom we fail to cooperate.

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