Debunking the Myths About Special-needs Patient Care

by Harvey Levy, DMD, MAGD

For me, working with difficult-to-manage patients is a rewarding and worthwhile challenge, which keeps me as enthusiastic about treating patients as I was 36 years ago when I started practicing dentistry. I have asked hundreds of dentists in different states and countries why they choose not to see more special-needs or otherwise challenging patients in their practices. I have heard 27 distinct replies, all of which I consider to be myths.

I have grouped these 27 myths into Administrative Barriers, Management Barriers, Medical Concerns and Financial Concerns. I will explore each of these myths and counter them with facts and different perspectives.

Administrative Barriers

1.It's too difficult to communicate with them.

It is not the patients' job to know our language; rather, it is our obligation to know how to effectively communicate with them. Anyone with teenagers will attest that at times, communication with a wall yields a greater response. If you place me in a country where I do not speak the language, I would appear inarticulate, noncommunicative and possibly even combative. It is our job to discover and recognize the "language" of each of our patients, and to establish contact. Often the communication happens with a soft look, a warm smile or a subdued voice. It is not always English, and it's not always verbal.

2.It's hard to get permission or consent to treat them.

It's not hard to get their consent; it's impossible and often illegal. This is why we always ask a legal guardian to approve the treatment plan. Usually this is the same person or agency who will manage the funds to ensure payment.

3. It's a problem that they rely on others for transportation.

Many of us rely on others for transportation, including children under 16. An agency's van or back-up vehicle can be even more reliable than a parent's or caretaker's car.

4.They don't keep their appointments or are late.

None of my special-needs patients have ever canceled or failed to show up for an appointment because they were stuck at work, had a meeting, couldn't get a baby sitter, or were drugged or drunk from last night's party. For them going to the dentist is an outing, and they are generally early for appointments, not late.

5.They are disruptive to the schedule.

A spoiled child who causes unexpected problems is far more disruptive than our special-needs patients. We learn what to expect from each special-needs patient during their first visit. For their subsequent visits we plan ahead, and are so well prepared that disruptions seldom occur.

6.I may have to treat them in a hospital, and getting hospital privileges is too difficult.

I love treating patients who not spitting, biting, jerking their head, flailing their hands, getting up to use the bathroom, texting or answering their cell phone. Usually such ideal patients can only be found asleep in the operating room. Since in the O.R. there is no possibility of any behavior or action precluding me from finishing the agreed-upon treatment, I can guarantee completion of the case. Finally, getting hospital privileges only requires a simple application, proof of liability insurance and dental degree, a CPR card, references and often a small fee.

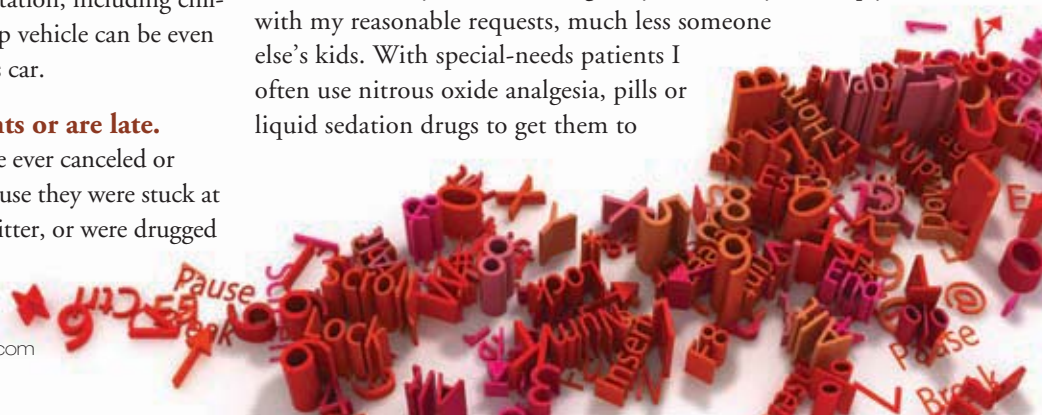
Management Barriers

7.They urinate, defecate, expectorate and vomit any where.

We ask all our special-needs patients to arrive with an empty stomach, which precludes vomiting. They are asked to use the bathroom before being seated. Those who cannot control their bladder, regardless of age, wear a diaper. The worst they can do is spit onto our protective face shields and masks.

8. I can't do quality work because they don't cooperate.

There are days I when can't get my own family to comply with my reasonable requests, much less someone else's kids. With special-needs patients I often use nitrous oxide analgesia, pills or liquid sedation drugs to get them to



cooperate. If this doesn't work, I increase the dosage up to the maximum recommended dose (MRD), or switch to a different family of drugs.

Once they're sedated I can use restraints and wraps to get them to sit still without flailing their hands, kicking their feet, or rotating their head (Fig. 1). I also use various mouth props to get them to open wide (Figs. 2 & 3).

If office sedation, wraps and props don't work, I can take these patients to the O.R., where IV sedation or general anesthesia is used.

9.I can't get good X-rays.

Dentists need X-rays to detect gross pathology or fine detail. A caregiver or employee wearing a double-lead apron can help obtain satisfactory radiographs showing gross pathology, such as impactions. We can obtain higher-quality X-rays when the patient is relaxed or sedated. If all else fails, we take the best X-rays when the patient is asleep in the O.R. Our greatest success is with the DEXIS sensor and a portable laptop, where we can take and retake X-rays within seconds. In the person's home, facility or even in a parked vehicle, we use the Nomad portable hand-held unit to take X-rays. We love the Ergonom-X self-developing films, which require only water and about 60 seconds to develop. These tools enable us to always obtain the diagnostic X-rays we require (Fig. 4).

10. I have to work around their wheelchairs and helmets.

If the patient chooses to remain in the wheelchair, using only one finger we can easily move our Dental-eze Airglide operatory chairs to the side or even out of the treatment room (Fig. 5). When a caregiver is not available to stand behind the patient and immobilize the head with their chest and hands, we use portable headrests. If the patient arrives with a helmet, we remove it and put it back on after we're done. It's not much different for us to work on a patient in a wheelchair, and it is more comfortable for the patient (Fig. 6).

11. They have poor oral hygiene.

In my lectures, I display photos of mouths with poor oral hygiene and have participants guess which patients are special-needs and which are not. Rarely can a clinician ever tell the difference. Poor oral hygiene isn't unique to special-needs patients.

12. My staff will not want to work on them. I have a hard enough time attracting good staff.

Whether we are incorporating a new technology, a new procedure or a new patient population, we need to train our staff. Reluctance to work on special-needs patients is often based on the lack of education about the subject. Share this or other articles with your staff, and have them attend a CE class on treating special-needs patients. In my experience, once they are educated, most staff will be as open and receptive to incorporating this population into your practice as they were for to lasers, implants, or Invisalign.

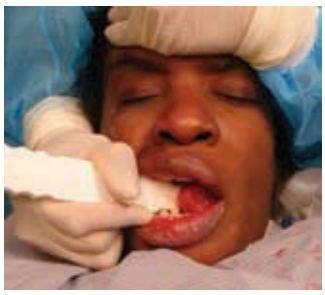
13. It scares me to be in their presence.

We fear the unknown, so at first glance some special-needs patients may appear frightening. My staff and I feel totally comfortable with mentally-challenged, autistic or Alzheimers patients, especially when they are being closely monitored by their caregivers. From our patients' perspective, it scares them to be in our presence.

14.It saddens me to work on these people – they have no future.

The future is promised to no one. Having empathy for someone whose mental or physical condition will never improve

Fig. 1: Rainbow wrap, feet restraint and nitrous oxide



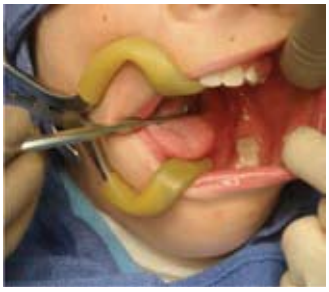


Fig. 2: Mouth prop: Mouth restFig. 3: Mouth prop: Ratchet

Fig. 4: Nomad handheld X-ray unit

Fig. 5: Patient remains in Wheelchair or gurney

Fig. 6: Working around a wheelchair

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or whose Alzheimers will not reverse is understandable. However, denying them dental care because their employment prospects are dim is insensitive and small-minded. Would you like to see your loved ones denied routine health care if they were old, wheelchair-bound or couldn't articulate their words clearly?

Medical Concerns

15. I'm afraid of having to use oral sedation greater than the maximum recommended dose.

MRDs are useful and practical guidelines for the great majority of cases. When confronted with a situation where the maximum is not quite enough, there are justifications for going a bit higher –if, and only if, you are knowledgeable and are prepared to handle potential emergency situations (which you should be for all of your patients anyway). Finally, if that fails, you can use parenteral sedation or general anesthesia, as described in Myth #8 above.

16. They have communicable diseases.

When was *your* last physical exam, and how often do you get thoroughly checked by your physician? These patients are less likely to be sick than the rest of us, because their health is more closely monitored. We are more likely to get sick from shaking hands with a friend, touching a doorknob or hugging our runny-nosed children than we are from working with these patients. With our standard barrier protection in the operatory, we are more protected against disease in our office than we are in an elevator or car.

17. If I don't have the skills to perform a procedure, there might be no one to whom I can refer.

Until I know that I am unable to perform a procedure, I feel obliged to give it my best try. If you have a phone, then you have a referral source. The decision to call a colleague or a dental school should be based on the procedure, *not* the patient.

18. If something happens, I might not be able to handle their emergencies.

Special-needs patients are far less likely to have an emergency in your office than the obese executive, the drug addict or the patient who has not seen a physician in a decade. Because their health is monitored closely, the preparedness protocols you have implemented in your practice already apply to special-needs patients, except they won't require them as often.

Financial Concerns

19. They're all on Medicaid and have no money.

I learned long ago not to judge an assets portfolio by a person's clothing. Our job is to present the best clinical treatment

plan, including alternatives, without making people's decisions for them. The patient's choice might surprise you.

20. It's too hard to ensure payment.

I would rather have a $50/month signed financial agreement for the care of a special-needs patient than be stiffed by a stockbroker who promises to pay for a bridge upon receipt of my monthly statement. Special-needs patients have legal proxies who properly manage their accounts; reneging on agreements is not an option. My collections rate from special-needs patients is greater than 99 percent. I cannot boast the same figure from my other patients.

21. I don't want to buy expensive special equipment that I won't use much.

I own a fancy treadmill that I've used three times in the past three years. You too may have bought a boat or another expensive item for which you never got your money's worth. The equipment required for this special population consists of wraps and props. The gentle Velcro body wraps (Fig. 1) range from $105 to $230, and are good for more than 100 uses. The disposable mouth rests (Fig. 2) cost about $1 each. Both these products, sold by Specialized Care Co., allow me to treat special-needs patients with almost no capital outlay.

22. I'm only asked to do low-level, low-fee procedures on them.

This statement is often followed with the explanation, "I don't want to spend my entire day doing extractions and dentures." Even though I can still make a good living from exodontia and prosthodontics, the procedures we perform on special-needs patients include all areas of dentistry. Other than financial barriers, the treatment should be based solely on each patient's needs and the dentist's skills. No other variables should enter the decision tree.

23. Their treatment takes too long and requires too much staff to be cost-effective.

Successful management of special-needs patients does require more staff and more time than other patients. If handled intelligently, however, this fact becomes an asset instead of a liability. I schedule my special-needs patients on my slowest day of the week. I also schedule their recalls on my slowest months of the year. While my colleagues are struggling with empty chairs on Tuesdays in August and December, our schedule is completely filled. Intelligent scheduling is what makes treating special-needs patients extremely cost-effective.

24. Their appearance and screaming frighten away other patients.

Young children can easily be frightened, thus we have set designated hours when only special-needs patients are scheduled. If someone calls with an emergency, we inform them that there may be mentally challenged patients in the waiting room. The caller is given a choice, and on rare occasions opts to bring in their young child at a different time. As you schedule more special-needs patients you may wish to inform regular patients, and offer them the choice of arranging a different time.

25. They won't refer anyone.

In 36 years we have never had a single referral from a special-needs patient. However, our practice accepts 900 new patients a year, with zero advertising budget; all come to us by word-of-mouth. We are referred by the families, the drivers and the caregivers of our special-patients. The caregivers themselves choose to support us by coming into our practice because they were impressed by your treatment of their clients or loved ones. More than one caregiver has told us, "I don't care how much you know until I know how much you care."

26. They are high-risk medical patients. I don't want to be sued for complications.

We have never been sued by a special-needs patient or their representatives. We have never even been legally threatened by them. They are so pleased and grateful that we reach out to assist them that they would be the first to defend us. I cannot say the same for our other patients, who are far more ready to sue. I have never met a special-needs patient who has been willfully unpleasant.

27. Dentists who treat these people are the ones who can't succeed with regular patients.

We choose to treat special-needs patients because we enjoy getting paid with grateful smiles and hugs, as well as monetarily. The mother of our young autistic patient says we are wonderful. The children of our Alzheimers patient consider us heaven-sent. We are heroes to the families of our profoundly challenged patients.

In conclusion, special-needs patients are not hard to treat, and you can make a very good living. If your hands are extended and your mind is open, these 27 statements – these myths – are easily debunked, and you can reap great rewards. ■

Author's Bio

Dr. Harvey Levy is a general dentist from Frederick, Maryland, who has earned Mastership and two Lifelong Learning Service Recognitions in the AGD, eight fellowships and four diplomate certifications. He has published numerous articles and offered seminars and participation workshops all over the country. His work with anxious and special-needs patients earned him the 1986 AGD Humanitarian Award, the ADA Access to Care Award, and the honor of being a 2002 Winter Olympic torch runner.