Why You Can't Treat the Poor

by Nareg Apelian, DMD

Or rather, strategies so you can

It was during a dental public health class, the instructor asked the students:

"How do you define poverty?"

There was no answer.

"OK… let me rephrase, who is poor?"

Someone in the front said, "We are poor."

"Do the rest of you agree with him? Are you poor?"

An emphatic "yes!" by everyone.

The third-year dental students at McGill University thought they were poor. And why not? They were up to their ears in debt, had no income and lived on Kraft dinner. What better definition of poverty? Even recent discussions on the Townie threads showcased a similar misunderstanding of poverty by dental professionals.

Dentists, and most other dental professionals come from a middle- to upper-class culture. The society they're exposed to is very different from those in the lower classes. Therefore, their understanding of poverty is strongly influenced by their upper-middle class culture.[1]

What is Poverty?

One definition pins poverty as the lack of financial, cultural and social resources.[2] It is not enough not to have money to be poor, you also have to lack education and a social support system (friends/contacts).

Once one falls to this level,[3] it becomes very difficult for generations to come, to leave the cycle of poverty. Once in poverty, health-care needs increase, and access to care decreases. In fact, the more one needs health care, the more difficult the access; the less one needs health care, the easier.[4]

Moreover, the quality of the health care the poor receives goes down as well. Not because we (health-care professionals) don't like the poor, or are heartless, but simply because we do not understand poverty. We do not understand the culture of poverty, so it becomes frustrating, challenging and financially unrewarding.[5] This seems to be true not only at the dental level, but also at the medical level. There is a lack of informational resources available to the health-care professional when it comes to treating underprivileged patients.[6]

In this article, I will be talking about the truly poor, not just the broke or those who can't manage their money, not those who prefer buying an iPhone instead of spending money on their teeth, but rather those who can't afford to predictably feed their kids, those who live in a one-bedroom apartment with multiple families, or those who come into a new country as refugees and don't know anyone or understand how the system works.

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How Do We Treat the Poor?

A recent study in Montreal[7] tried to capture the perceptions and expectations patients on social assistance had about their oral health. The main recurring themes were: Those surveyed (a) define oral health in a social manner, placing tremendous value on dental appearance; (b) complain about the decline of their dental appearance and its devastating impact on self-esteem, social interaction and employability; and (c) feel powerless to improve their oral health and therefore contemplate extractions and complete dentures.

Another study showed dentists in Montreal[8] working in underprivileged areas and willing to treat poor patients had five social traits in common:

1. *Ruby Payne, "A Framework for Understanding Poverty"*
2. *http://www.ccdonline.ca/en/socialpolicy/poverty-citizenship/income-security-reform/quebec-law-poverty-exclusion*
3. *http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10390891*
4. *Hart JT. The Inverse Care Law. Lancet. 1971; i:405-12. http://www.sochealth.co.uk/history/inversecare.htm*
5. *Dentists' experience with low-income patients benefiting from a public insurance program. Pegon-Machat E, Tubert-Jeannin S, Loignon C, Landry A, Bedos C.*
6. *The GP's perception of poverty: a qualitative study. Willems SJ, Swinnen W, De Maeseneer JM*
7. *How people on social assistance perceive, experience, and improve oral health. Bedos C, Levine A, Brodeur JM. J Dent Res. 2009 Jul;88(7):653-7.*
8. *Providing humanistic care: dentists' experiences in deprived areas. Loignon C, Allison P, Landry A, Richard L, Brodeur JM, Bedos C. J Dent Res. 2010 Sep; 89(9):991-5.*

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1. Understating the Patient's Social Context

The dentist needs to understand poverty. He needs to understand how poor is poor. He needs to understand the patient has a value system. Practically, this means treatment planning will have to accommodate the patient's wallet. A lower prognostic procedure might need to be done, since the alternative is extraction with no replacement. Other times, extractions need to be done, even if the alternative (costlier) treatments have predictable success rates. The dentist has to be comfortable with those decisions. Moreover, the dentist will have to understand, accept and respect the patient's choices. Record keeping will have to be very thorough.

2. Taking Time and Showing Empathy

For any type of healing to occur, a bond needs to form between the dentist and patients. This takes time to forge, and the dentist will have to understand, feel and validate the patients' concerns. The underprivileged patient is more difficult to communicate with and more difficult to connect to. The dentist will have to take the time and listen to the expressed concerns, understand them and respect them.

"Practicing dentistry for people who are poor is not for everyone. We all have different values, different ambitions, different motivators, which change throughout our career."

3. Avoiding Moralistic Attitudes

The dentist should avoid blaming the patients for their oral problems. Rather, he or she should accept the situation and find ways to reach a solution, compromised or not. There's a widespread bias that the poor are poor because they are lazy, and the rich are rich because they work hard. Given that bias, some dentists might be more judgmental. However, poverty, or rather the cycle of poverty, might be more related to luck or something into which someone is born. Nobody wants to be poor. Moreover, these patients have enough other issues to worry about, and if they don't value their oral health the way the dentist does, it's understandable. The best the dentist can do is educate them, accept the fact that little might change, and treatment plan accordingly, encouraging planned out treatments where the behavior can be observed, and the plan modified.

4. Overcoming Social Distances

The dentist has to adopt a humanistic attitude when dealing with underprivileged patients. The perception of a social gap between the two should diminish. The patient should feel the dentist is close enough to his socioeconomic group that he can connect with him. Sometimes, under the impression of wanting to be professional, the dentist could create a social gap. The language used has to adapt to the listener. The tone has to be unpretentious.

5. Favoring Direct Contact with Patients

The dentist has to establish a warm rapport with patients, instead of having the patients go through multiple "middle men." The patients should be made to feel comfortable enough to ask questions directly to the dentist, with no inhibition or fear of being judged. In essence, the dentist has to spend more time actively listening and talking to the patients. All concerns need to be validated.

The underprivileged patient requires more time, more understanding, better communication and more flexibility from the dentist. All that, at a lower fee!

A Proposed Model

Since there is a lack of literature on how to treat people who are poor, all I can do is describe a model that has worked for me over the years, a model that has been refined with a lot of trial and error.

I strongly believe the solution to improving health care for the underprivileged needs to have good incentives. We cannot rely on dental professionals' goodwill, generosity and social consciousness to resolve the problem. It's not up to a few dentists to carry the entire social burden. That model would not last very long.

The biggest hurdle is remuneration. Whether paid by the government or directly by patients, dentistry needs to be done at a lower price than in other neighborhoods. This means profit needs to be made at lower prices, which means a low overhead is crucial.

Low overhead means either less expenses or more hourly income. There are a lot of resources on how to increase hourly production. My model focuses more on how to lower expenses. There are probably many ways to do this effectively, but I can only talk about the way I approach the access to care issue, while keeping in line with my values.

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My Small Office

Located in one of Montreal's poor neighborhoods, Park-ex,[9] my 800-square-foot office caters to a mostly refugee or recently immigrated south Asians (India, Pakistan, Bangladesh, Sri Lanka), most of whom have never been to a dental office, at least not in Canada. Culturally, dentistry for them is more of an emergency procedure and less of a preventive measure, even though most of their basic dentistry is covered by the government (the dentist gets paid 50 to 70 percent of the provincial fee guide directly by the government).

I work out of a two-op practice with no receptionist and one assistant. Having no receptionist means I greet the patients as they come in and accompany them to the op. Once the work is completed, I accompany them back out, do the paperwork (payment, insurance or welfare processing) and book their next appointment, while my assistant cleans the room and preps for the next patient. Throughout the day either the assistant or I answer the phone, whoever is less busy. At the end of the day, we both clean up the office and prepare the front desk for the next day. There are no tasks "too low for the dentist."

Being a small office means I can run it like a small business. Fewer patients mean scheduling is not complicated. Payroll is done with a simple Excel sheet. Accounts receivable are only a handful and easy to track and stay on top of. Rent is low (small office size and inexpensive neighborhood). Hours are flexible (only one staff to manage). Time off is flexible: we work more during busy periods and take it easy when it's slower.

This model enables me to have more contact time with the patients, which helps us understand each other better. Their dental visit is more of a "visit with the dentist" as opposed to a "visit to the dental office." Since many of my patients have a limited control of the English language, they appreciate dealing with the same person each time they visit. Moreover, the lax structure makes it easier to spend the extra time with those who need it, whether in the op or at the front desk.

This "feature" is used as a marketing angle, emphasizing the "mom and pop" style practice philosophy and the unpretentious image. Internal reinforcements are made explaining the non-essential services have been cut in order to keep the dentistry quality high and fees low. Financially, the low overhead keeps the profit margin within the provincial average. Sure, the maximum potential income is more limited (there's a limit to how many patients one can treat with this set up), however, the advantage of keeping things small and flexible might be attractive for some. Also, the fulfilling feeling of having a direct social impact needs to be taken into account as well.

A Social Solution

Practicing dentistry for people who are poor is not for everyone. We all have different values, different ambitions, different motivators, which change throughout our career. Once part of an established clinic, the likelihood of leaving the stable job and jumping into the wild world of poverty dentistry is very low. From a social perspective, it would make more sense to identify those who are interested in this type of practice at the university level, and show them the different options they have. Those university students are often afraid they will graduate and go bankrupt; they are not exposed to the different business models. All they know is what they've seen at their own dentist's office, and since most dental students come from mid- to upper-mid socioeconomic classes, they're typically exposed only to that specific model. Others graduate and end up in fast-paced mills, and that's the impression they get of treating the poor. The fast pace is not something to which the new graduate can easily accustom.

I think a program could be implemented that lets interested dental students spend a day (or two) in a variety of offices in poor neighborhoods with different practice styles. This way they can experience different dentists' perspective, and let those who are naturally attracted to a more socio-humanistic practice know there are different ways to practice dentistry, each with their advantages and disadvantages.

Treating the poor can be very rewarding on a personal level. It's more of a lifestyle than a means to an end. ■

Author's Bio

Dr. Nareg Apelian earned his DMD in 1996 from Université de Montréal. He then worked as an associate at multiple places and eventually bought his own office in 2001 in one of Montreal's poorest sectors. When he's not working, he enjoys his family and playing ping pong.

9. *http://en.wikipedia.org/wiki/Park_Extension*