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Special Deeds for Special Needs: Humans First, Needs Second

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INTRODUCTION

For many years, most practitioners considered patients with specific types of "handicaps," persons with "Special Needs." Those individuals who suffered from various types of congenital and developmental issues were lumped into this category. Approximately 17% of children today have a developmental disability ranging from mild disabilities such as speech and language impairments to serious developmental disabilities, such as intellectual disabilities, cerebral palsy, and autism. Over 6 million individuals in the United States have developmental disabilities. 10% of the world population are disabled. This accounts for approximately 650 million people with disabilities (https: www.cdc.gov/ncbddd/developmentaldisabilities).

I can remember back as a dental student my fear of working with this genre of patient, which stemmed from my lack of knowledge about them and their ailments, both as a dental student and as a youngster growing up in a "sheltered "environment. We did not get much experience with disabled patients in dental school back then, need I say more. In a state of desperation, I took it upon myself to get permission to visit a facility outside Philadelphia, Pennsylvania, as a dental student, where what we were told were "brain damaged, 'retarded', 'malformed', and 'congenital 'anomalies in persons who were living there and so on." No one knew what to label

all these people and the categories of their ailments. In this facility, I saw people that did not look like people, nor did they act like the seemingly "normal" people I knew or had known in my past, nor did they communicate in a way that I could understand, for the most part. I knew that I had to challenge my fears and anxieties with respect to these challenged individuals and the only way to do it was to immerse myself in this residence for at least a week and interact with as many of these people as I was allowed, with supervision. The facility was old, run-down and "dark." The mood that the surroundings had sent was one of despair and sadness. People were warehoused in rooms with a glass window in front of locked doors.

The first person I met in this facility was a youngster of about 15 years old, who I thought was "Retarded." He was skiing with his father and riding on a lift by himself, he was "goofing off" and slipped off the chair lift only to hang himself by his scarf that got caught in the chair, which as a result, cut off his airway for just enough time to cause irreparable brain damage. Subsequently he had the mind of a 3 to 5-year-old and spoke baby talk. He had fits of anger, acting out without provocation and more. His parents felt so guilty about the accident that they hardly ever came to see him. I played with this youngster, held his hand, and talked with him, all the while my heart was racing, and my mind kept trying to figure out what I would do if he got violent with me, which he never did. After a week with him, we were both friends and I felt at peace. Over the next year of dental school, I often came to visit him and others in the facility that I had made friends with; and I was always received with open arms and a smile Another person I came across was a man who had a very large hydrocephalic head. All I remember seeing were his daunting eyes that followed me as I came into the room. I was scared but accepting and said hello. The person greeted me with a smile, which eased my angst. All I could think about was "Humpty Dumpty" when I looked at him!

This experience was the start of my evolution into the world of people that most others did not talk about, treat in the dental school or who were rarely seen in public, for the most part. While teaching at the University of the Pacific School of Dentistry as an assistant clinical professor, during the 1980's, I developed courses dealing with medically and physically compromised patients. I had senior students go with me to a county hospital in San Francisco for disabled and medically compromised persons (Figure 1).

I introduced them to the same kinds of patients I saw when I was a student and went to the "sanitarium" to learn about the disabled patient, and to do head and neck screening examinations coupled with complete oral examinations, as well as to quell their anxiety about working with disabled persons. We found at least an 8% incidence of undiagnosed medical issues among this cohort of patients. Most all these patients were under Medi-Cal financial

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care. Medi-Cal would only pay for a small percentage of treatment rendered, including a physician's examination once every 12 months if that. This was difficult to believe at first, but with the shortage of internal medical care within the facility and the low caregiver/nurse to patient ratio, I can understand the difficulty.

Figure 1: 60 yr.-old cerebral palsy patient- A "special" patient with special needs.

These findings are important facts for the dental practitioner who can effectively find and catch medical, as well as dental issues before they blossom into something more deleterious for the patient. It was a good teaching program for the dental student but did not last more than one year, as it was deemed not something the dental student would regularly have to confront, and who did not need the knowledge from this experience to pass the State Board exams. Ah, the power of Bureaucracy! Today, there is a category of care for the person who is a "developmentally disabled "person. However, the category of a "Special Needs" patient should be addressed differently today. As a professor that treats and teaches others about older individuals in our Society, who may be impaired in some way, it is important to realize that they too are considered "Special Needs" patients when the aging process causes havoc with their minds and bodies. Re-labelling these types of patients should be considered with the knowledge that we are dealing with a Human first and a specific disease entity or developmental disability that changes the image of a "normal" Human into one that is somewhat abnormal in the face of Humanity. So, what is it that allows each of us the ability and where-with-all to treat this segment of our society? Think about it and what you may be anxious about……

AN OVERVIEW OF SOME DEVELOPMENTAL DISORDERS

Autism

Autism is Spectrum disorder. Autism is a pervasive developmental disorder in which excesses and deficits in behavior are observed that have a neurological basis. This congenital issue is a lifelong disability, and it is complex and unique to the individual that it inherits.

Epilepsy *Vs* A seizure

1. A seizure is a single occurrence

2. Epilepsy is defined as having two or more unprovoked seizures

3. Generalized seizures beginning everywhere in the brain at once

4. Partial seizures begin in one location of the brain.

5. There are gran mal seizures, petit mal seizures, and pseudo-seizures.

These types of seizures need to be dealt with immediately and the practitioner needs to be prepared to identify them when they occur and to give emergency care until paramedics arrive.

Cerebral Palsy (CP)

A congenital disorder of movement, muscle tone, or posture. It is caused by abnormal brain development, often before birth. The majority of people with CP do not have an intellectual disability. Some treatments can help, but this condition cannot be cured. Approximately 40% of people with CP have an intellectual disability accompanying their physical condition.

Before your initial oral examination, it is imperative to gain insight into who you will be working with as a patient. These are what is necessary before we start treatment on patients who need special attention:

1. A thorough medical History, including pharmacology list of current medications, dosage and number of times taken during the day.

2. Allergy list Including drugs and foods.

3. List of adverse drug reactions (ADR) to any drugs or medicines or vitamins.

4. Behavior history and willingness to have dental care.

5. Heart check for any arrhythmias, and regular beat; blood pressure; oxygen saturation numbers; BMI (Basal Metabolism Index); blood sugar reading, and respiration, as well as Mallampati level (Opening of the oropharynx, #'s 1-4).

6. Personal contacts with family and caregivers as well as the general treating physician(s).

7. A thorough dental history, including previous care, radiographs of any kind (most recent radiographs needed).

8. History of sedation and/or general anesthesia (How many times? And favorable or unfavorable results?).

9. Home care: is the home care done by the patient? What type of dental oral care is being done and how often?

10. Is home care being done by a caregiver/family member or friend? How often and what kind?

Long-term care regimens can be deleterious to a compromised individual in the form of both physical and mental issues which can arise because of medications and the like. We practitioners need to be aware of the medication being used regularly and the dosages and use thereof for side-effects that may be even more damaging when the patient is under sedation of some kind for dental care and treatment.

Symptomology

1. Be aware of high sugar levels due to the liquid ingredients of the medication being administered.

2. Be aware of reduced salivary flow causing xerostomia

secondary to psychotropic medication and anti-seizure medications, high blood pressure medication and antihistamine's, to name a few.

3. Look for gingival hyperplasia secondary to Dilantin and calcium channel blockers.

4. Be aware of all medications and medical conditions that the patient brings with them and the side-effects from both the disease states and the medications especially.

THE GOLDEN RULE OF PATIENT CARE

1. Every patient with or without a disability is an individual.

2. What may work for one patient, or one practitioner may not work for another,

3. If one patient is treated on a different day, by the same clinician, with the identical treatment, it may not work; OR the same treatment by another clinician is delivered on the same day, "it may work."

An important aspect of treatment is the *Treatment Plan*. I recommend an outline first of where it is you want to go with respect to treatment based upon the needs of the patient, whether "challenged" or not. The "Special Patient" with special needs should have a more involved treatment plan, but none the less important. This plan might consider general anesthesia for completing the intended treatment or sedation of some sort.

We are looking at patient centered treatment

1. Start with the ideal based on your outline.

2. Consider the patient's Abilities, Wants, Needs and Desires (assuming the patient can communicate with you effectively.) A Caregiver, Guardian and/or a Power of Attorney should be involved with disabled patients that cannot communicate or think for themselves.

3. We need to consider the patients ability to tolerate treatment and maintain both the restorations and continued oral health.

4. Consider at the beginning of dental care the possible adaptations and modifications that may have to be made as an alternative treatment.

5. Consider at the onset making multiple treatment plans for each patient, which one can mix and match.

PHYSICAL LIMITATIONS

1. Consider the scope of the patients' ability to perform adequate home care and the need for adaptive hygiene devices and care. This would be for all persons of any age with one form of disability or another.

2. A caregiver may be necessary to provide homecare for the patient and one should not only be prepared for this but attempt to pre-discuss this aspect of care prior to treatment with the patient and/or relative/power-of-attorney.

3. A caregiver may have to be instructed by the dentist in adaptive care and the necessary steps to keep the patient in a state of good oral health daily.

Physical Disabilities

1. Before starting treatment with a Developmentally Disabled patient, know the tenets of the requirements of the Americans with Disability Act.

2. Make sure you have the space to accommodate a person with disabilities, such as a wheelchair, crutches, cane, and the like. I was always able to move my dental chair to make space for those that could be treated in their wheelchairs. This made it easy for them as well as my hygienist and myself.

3. Be prepared to transfer said patients to the dental chair itself or an operating room type table in your operatory.

4. Have adaptive aids and an emergency kit available for all patients. We had foam arm and leg rests to keep the patient from cramping, while in a long-term position during treatment.

5. Be prepared for hearing impaired patients and how you will communicate with them rather than raising your voice. A small white board is good to have for any patient that suffers with hearing loss. You can write down what you are going to do and what the patient should expect.

6. A patient's vision should be protected, and the patient should be informed as treatment progresses as to what is going to happen and what you are doing on a constant basis. This diminishes anxiety and fear on the part of the patient and will help assuage the difficulty the patient may sense and any discomfort he/she may be feeling. This behavior will also lessen any problems or frustration the practitioner may have as well during the process.

MINIMALLY INVASIVE DENTISTRY SHOULD BE IMPLEMENTED AT ALL TIMES

There are many more pieces to this puzzle in treating special patients with medical, dental, and medically compromised systems, as well as developmental disabilities. It is important to know them all so that you can solve the puzzle for yourself. This article is only the first step in treating this type of patient. It's meant to "wet your whistles!" I spent over a year, working for a dental anesthesiologist. He would provide the general anesthesia for the disabled patient, and I would do all the dentistry within a 2-to-5-hour time frame depending upon the extent of needed treatment (Figure 2-8).

It was difficult and yet, important work. It was fulfilling and sometimes frustrating because I had little to no communication from many of the patients before, during, and after the procedure. I dealt mostly with their parents / power of attorney, spouses or a relative or caretaker. The examination was a priori and usually taking place under general anesthesia. The treatment phase either followed immediately after the examination, or at another time depending upon the extent of treatment and making adequate financial arrangements with the family. Another paper on the subject can and will discuss these important aspects of care and caring for "special people" with "special needs." In the interim, read and study about the different traits that developmentally disabled patients can have and bring with them to the dental office when seeking out care. Think about the extent of the examination and what is important to accrue in the process. Discover what disabled seniors need and how to work with them. There is an entire gamut of people out there that need our expertise, care and caring.

Figure 2: Dental operatory of specialized equipment for IV Sedation or General Anesthesia of an anxious or special needs patient.

Figure 3: Cognitively impaired 80 yr.-old patient needing "special" care.

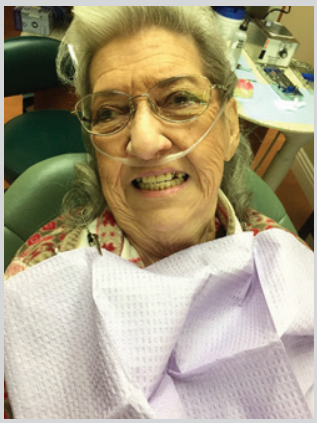

Figure 4: 80 yr. old special patient, with medically compromised lungs, heart and mouth.

Figure 5: 30 yr.-old Down's Syndrome patient undergoing general anesthesia for dental treatment.

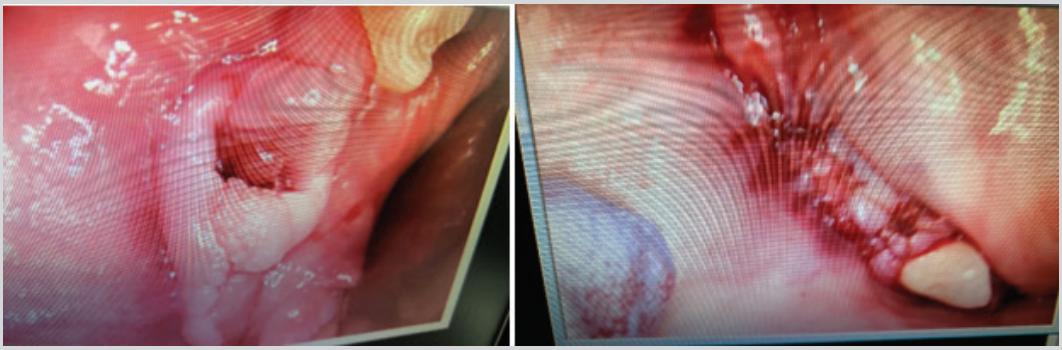

Figure 6: Surgical extraction of mobile tooth with bone defect in a Down's syndrome, partially edentulous patient.

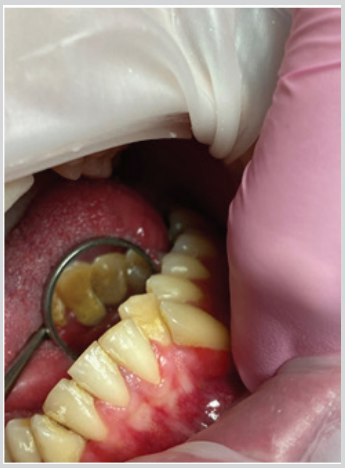

Figure 7: Developmentally disabled individual age 30, with periodontal disease.

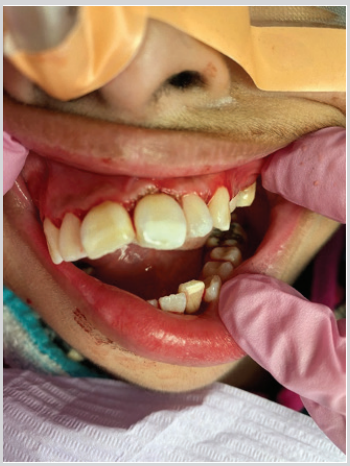

Figure 8: 30 yr. old, developmentally disabled and Cognitively impaired" Special Patient" post LANAP (Laser Assisted Attachment Procedure) periodontal treatment for pocket and inflammation reduction.