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*Guest Editorial*

# The time factor: One of the major elements in the therapeutic evaluation in gerontology

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## INTRODUCTION

The philosopher Emmanuelt[1] introduced the transcendental notion of space and time. If space is an easily perceived element, time is more volatile. Split into an infinity of components; it is more difficult to grasp and needs memory to situate itself. In our dialogue with the patient, we constantly call on his memory to compose and then start the treatment plan. It is evident that each of our patients has his memory and his notion of time. The same minute is not perceived similarly by a young person or an elderly person, or even by an individual in anguish or calm. We must, therefore, try to decipher this element or "Impact factor" in our daily approach.

## THE DEVELOPMENT OF THE KNOWLEDGE IN ORAL HEALTH

The changes in oral care and the increase of the cohort of elderly people will have an important impact on daily practice. Unfortunately, there are dogmas which are dragging down the treatment to a pitfall. A side the classical reasons of dissatisfactions. As an error in the diagnostic, errors by the laboratory, a bad treatment planning, and a missing maintenance program there is an important factor; the time factor which is a major element in the therapeutic evaluation of the treatment. This concern not only the time-schedule of the patient but also the fatigue and burn out of the dentist. This issue is now recommended in our continuing education program.

## IMPORTANCE OF THE MEMORY

From the time of the anamnesis, we can perceive the troubles of the memory. In general, a session of 15–18 min is recommended for this examination. Often an accompanying person is present and intervening with the conversation. It is recommended returning this person to the waiting room. Memory should be continually solicited, even if the answers are unlikely. To build a good record, it is essential to reconstruct the puzzle of episodes and the continuation of past treatments. In the explanations given by the practitioner, the patient must be able to grasp the chronological sequences of the therapeutic and restorative stages. Without addressing the serious neurological pathologies, many figures of memory imperfections exist.[2]

## THE LACK OF UNDERSTANDING

This could be a total or partial; often the entourage fails to grasp the different stages of the treatment and its distribution by sequences in time. An accumulation of technical details confuses more often than it

helps to clarify the therapeutic approach. This fact is aggravated by the presence of aggressive publicity and the new tendency to consult for advice and quote several colleagues. This accumulation of information obstructs the memory and makes difficult the most elementary explanations. As a result, it takes a significant amount of time to be confident that the message has been well understood and recorded.

## TIREDNESS

The "burn out:" The mass of information grows with the development of new means of communication; for elderly patients, called "seniors," this poses serious problems. The practitioner must also manage this flow of data and he is constantly called on to modify his agenda. The result is a bottleneck of memory that, in the end, gives constant anxiety to the patient and the practitioner. The patient immediately perceives the tension in his caregiver, and this furthermore blocks his memory and, ultimately, his cooperation.[3]

## EPIDEMIOLOGY

Many researches have led to obvious findings regarding oral health in these patients.

Globally, this is characterized by:
1. Poor hygiene
2. Acute periodontal problems
3. Residual teeth affected by caries (collars, roots, and proximal)
4. Old restorations deficient
5. Improperly adapted and wounding prostheses
6. What should be noted the frequency of the pathology due to Candida as well as the threat of cancer lesions.

This table will strongly influence the treatment plan and emphasize the need for a program and time, to achieve satisfactory rehabilitation.

It must also be admitted that there is often deterioration in chewing resulting in an anarchic mastication cycle.[4]

## THE RISKS

The main risk from the anamnesis is the incomprehension, and then the forgetfulness of the explanations provided and often repeated by the practitioner. A certain confusion is, thus, established between what the family wants and what the patient wants to understand.

The second risk is the appearance of latent fatigue that turns into a state of crisis and the refusal to continue treatment. In this situation of conflict, the patient leaves the office and often addresses a colleague who, unfortunately, will not take into account the initial treatment plan.

The third risk is a complete absence of care, hygiene, and control, in a patient desperate and left to himself.[5]

## FINANCES

It is a chapter that, by tact or by deontology, is often overshadowed. Good business sense means that when they are paid, the work must be carried out and delivered within a very short period of time. The time factor becomes very important, leading to impatience and ultimately to a lack of credibility.

With the breakdown of the patient-practitioner contract, the family or the environment will not fail to demand the reimbursement of the entire sum.[6,7]

## TO HELP OUR COLLEAGUES OVERCOME THE PROBLEM OF TIME, WE PROPOSE THE FOLLOWING PARAGRAPHS

Courses of action:
1. Before the treatment
2. During the treatment
3. After the treatment.

### Welcome and Anamnesis

The first image and the first impression are the main elements.

Everything must be calm, clear and orderly, and even secure. The forms to be filled often confuse the patient and at the end, the information is sometimes inaccurate. A too long waiting will increase the nervousness of the patient especially if he presents himself well in advance.

The practitioner must, therefore, re-check everything during the first contact. This first interview is delicate because the patient wants to expose his complaints, which are usually focused on oral disorders.

The patient constantly returns to these points because he is afraid either to forget or he is anxious; on the whole, he doubts that the practitioner can be able to fully understand his problem.

The practitioner must, therefore, carry out his examination with tact and authority to have an overview. The examination of the prostheses will be carried out at the end of the consultation. The patient will, therefore, understand that you are looking to treat the cause and not the consequences. He will then realize that the treatment will not be quick and that it will be necessary to invest in "time." At the end of the session, the practitioner will not be in a position to provide a complete treatment plan which will include all the steps, nor evaluate financial commitments. Certainly, the patient will be disappointed by the prospect of having to come back again, but it is better to lose ½ h rather than to give rough information that the patient or the accompanying persons will preciously record. It is also recommended to take fingerprints of studies that can be used for individual impression trays and explanations during the second session.[8]

After having had the "time" to analyze all the components, the practitioner will be able to draw up a treatment plan, which

obviously includes the time sequences. The practitioner may present one, two, or maximum three alternatives. However, he should avoid providing too many technical details. It is advisable to present, in writing, a clear and comprehensible plan. After his explanations and if the patient and his entourage have expressed their consent, the practitioner will discuss the financial consequences of the treatment and its "duration." A period of reflection may be granted, but in any case, the fees for these consultations must be paid.

**During the Treatment**

According to the diagnosis, several sequences can be conceivable:

a. The emergency care and the palliative sequence
b. The transitional steps
c. The restorative phase.

- Emergency care is provided by ethical obligations. The practitioner must prevent the deterioration of the patient's condition and relieve him of his pain. It will have to find the "time" to meet these imperatives, but in no case start the global treatment, which will be handed over to another session. The palliative sequence requires one or more sessions devoted to the elimination of pathologies, to reestablish a minimum of a chewing function, to provide an esthetic improvement, and above all to initiate acceptable oral hygiene.[9] This sequence is obligatory and allows to test the degree of collaboration and participation of the entourage. The amount of each intervention must be invoiced and paid. The duration of this phase varies according to the medical and psychological state of the patient and the need for patience and "time." At this stage, before starting the transitional steps, a reassessment is required. This concerns the patient: Does he have the strength and will to continue a long treatment and is the practitioner sure to be able to carry out this treatment in due time. This is the moment to suspend or stop the treatment because at this stage each of the parties is free to choose.
- The transitional stages are intended to prepare the "field" for the final restorative phase. This may include small surgery, endodontic, periodontic, temporary fixed, and/or removable prostheses. As a result, it is difficult to predict the time required to realize the program. Failures and, as a consequence, changes in the initial treatment plan must be anticipated, which inevitably result in loss of time.
- The restoration phase is the culmination of the whole process. The patient expects intensely this session, everything must be used so that all the pieces fit perfectly, and the esthetics, as well as the phonation, are presented in an optimal way. It is, therefore, a long session that is to be expected because it is obviously not possible to send away a discontented patient, without supervision and delivered to himself. It is absolutely necessary to establish a follow-up which will reassure the patient and relieve his suffering.[10]

**After the Treatment**

The responsibility of the practitioner does not stop with the installation of the prostheses; his duty is also to follow in the "time" the destiny of his achievements. Regular visits are imperative to monitor the state of hygiene, the condition of the prostheses and the constitution of the supporting tissues. The pain threshold is decreasing; the pathologies appear without causing reactions in the patient. The prostheses chip and become hurtful, candidiasis develops, cancers can appear in the oral cavity. Occlusion collapses causing chewing disorders, paralysis, and malnutrition.[11]

All these disorders are common and can occur about 3–5 years after the prosthesis placement.[12]

Epidemiological studies have shown that the large mass of patients only consults their dentist after 10 years.[13,14] It is, thus, necessary to establish a regular and serious reminder of the patients to be able to palliate in "time" wanted to these different problems.[15,16]

## CONCLUSION

To be able to measure with the time factor, it is imperative to follow certain rules:

- Establish a simple and clear treatment plan, with re-evaluation opportunities at certain stages.
- Choose options with minimalistic interventions:

Minimalistic intervention dentistry.

- Use technological breakthroughs for the well-being and comfort of patients as well as for the calm and satisfaction of the practitioner.

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