The perception of the HIV/aids patient about the dental surgeon

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Abstract

This study aimed to analyze the perception of dentists by patients with HIV/AIDS, seeking to understand the stigmatized face of the epidemic. This is a quantitative study with 67 HIV/AIDS carriers, participants of the non-governmental organization "Gestos – Comunicação, Soropositividade e Gênero" (Gestures – Seropositivity, Communication and Gender), in Recife/Pernambuco, Brazil. Questionnaires were applied on aspects inherent to professional stance, patient/dentist relationship and experiences during dental care. The results indicated that 31% of the patients did not inform the dentist about their status as seropositive and among those who reported, more than 30% reported that there was a change in the professional stance. Hiding the seropositivity from the dentist is a way of ensure care for 57% of the interviewees and 27% reported experiences of discrimination. It is concluded that the findings on HIV/AIDS have not been able to eliminate the historical prejudice and stigma that affect HIV +, seeing that there are still feelings of discrimination experienced by the carriers, including in the health care.

Keywords: HIV. Acquired immunodeficiency syndrome. Prejudice. Social stigma. Dentistry.

Resumo

Percepção do portador de HIV/aids sobre o cirurgião-dentista

Este trabalho objetivou analisar a percepção de pacientes com síndrome da imunodeficiência adquirida sobre o cirurgião-dentista e compreender a face estigmatizada da epidemia. Trata-se de estudo quantitativo com 67 portadores do vírus, participantes da organização não governamental "Gestos – comunicação, soropositividade e gênero" em Recife/Pernambuco, Brasil. Foram aplicados questionários sobre aspectos inerentes a questões como postura profissional, relação paciente/dentista e experiências durante atendimento odontológico. Os resultados apontaram que 31% dos pacientes não informaram ao dentista sua condição de soropositivo e, dentre aqueles que informaram, mais de 30% relataram que houve mudança na postura profissional. Ocultar do dentista a soropositividade é forma de garantir o atendimento para 57% dos entrevistados, e 27% relataram ter sido discriminados. Conclui-se que a evolução do tratamento da doença não foi capaz de dissolver o preconceito histórico e o estigma que afetam as pessoas infectadas, visto que ainda sofrem discriminação inclusive na área da saúde.

Palavras-chave: HIV. Síndrome de imunodeficiência adquirida. Preconceito. Estigma social. Odontologia.

Resumen

La percepción del portador de VIH/SIDA sobre el odontólogo

Este trabajo tuvo como objetivo analizar la percepción de pacientes con Síndrome de la Inmunodeficiencia Adquirida sobre el odontólogo, y comprender el costado estigmatizado de la epidemia. Se trata de un estudio cuantitativo con 67 portadores del virus, participantes de la organización no gubernamental "Gestos – comunicación, seropositividad y género", en Recife/Pernambuco, Brasil. Se aplicaron cuestionarios sobre aspectos inherentes a cuestiones como postura profesional, relación paciente/dentista y experiencias durante consultas odontológicas. Los resultados mostraron que el 31% de los pacientes no informó al dentista su condición de seropositividad y, entre los que la informaron, más del 30% relató que hubo un cambio en la postura profesional. Ocultar al odontólogo la seropositividad es una forma de garantizar la atención para el 57% de los encuestados, y el 27% reportó experiencias de discriminación. Se concluye que la evolución del tratamiento de la enfermedad no fue capaz de disolver el prejuicio histórico y el estigma que afectan a las personas infectadas, dado que aún sufren discriminación incluso en el área de la salud.

Palabras clave: VIH. Síndrome de inmunodeficiencia adquirida. Prejuicio. Estigma social. Odontología.

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Declaram não haver conflito de interesse.

Research

The human organisation model configures societies divided into groups formed from the identification between individuals. The attributes and characteristics of people are used as tools capable of categorising them and defining their "social identity" [1]. Even with all the plurality of the population, the points that flee from the dominant homogeneous mass are antagonised. Concepts are created of what is normal and what is unusual, and thus the social stigmas are born.

The term "stigma" refers to the condition or particularity deemed harmful to the collective, capable of diminishing the value of the individual and marginalising him or her in society. Commonly, stigma becomes greater than the subject: their qualities are dissolved by the mark they carry and, because of this social representation, they become rejected and / or isolated [2].

In the 1980s, the discovery of the human immunodeficiency virus (HIV) generated worldwide uneasiness, mainly because of the controversy between disease and sexual behaviour [3]. Because it was initially called "gay plague" or " gay cancer", it incited the prejudice that already haunted some minorities [4]. Another determining point in stigmatising AIDS was its association with injecting drug users [5].

The correlation of the disease with certain groups and lifestyles was determinant for the historical, cultural, imaginary and social construction of the pandemic [6]. For all these factors, the fear of being infected by HIV was presented as a reflection of an obscure prognosis, without cure and fatal. This generated significant repercussions in health and was responsible for changes in the posture of the professionals - mainly dentists, whose management of dental instruments with body fluids (saliva and blood) generated alertness for the risk of contagion and consequent resistance to attend patients with the disease [7].

Therefore, it is extremely important to analyse the current scenario of AIDS, as well as to see if the dentist is safest and most enlightened to deal with the virus, according to the perspective of those infected. Thus, this work aimed to outline the social representation that people living with the disease - in this case, regulars who frequent the Gestos NGO - have about their dentists, based on their experiences and perceptions of dental care.

Method

This is a quantitative study carried out at the NGO mentioned above, located in Recife (Pernambuco, Brazil). For 25 years, the institution has dedicated itself to the human rights of HIV-positive people and the formation of information multipliers in outlying communities. In this context, the perception of dentistry care could become broader, more in keeping with reality, since people with little critical vision and no clear understanding of rights tend not to distinguish the discrimination situations experienced by themselves.

The sample consisted of 67 HIV/AIDS patients, who participated in the activities promoted by the organisation. Included in the study were volunteers with positive HIV diagnosis, of both sexes, aged 18 years or older and who had undergone any type of dental treatment at least once. The individuals were contacted during their activities and visits to the NGO.

All participants received a letter explaining the study's objectives and procedures, as well as an informed consent form. At the NGO itself, a questionnaire was used to inquire about the patient / dentist relationship, access and dental care. The document had seventeen questions, of which fifteen were objective and two were open. It was not necessary to identify the participants in the data collection sheets.

The analysis was made using Pearson's chi-square test or Fisher's exact test, when there were no conditions to use the first one (inferential statistics techniques), with a 5% margin of error. One of the risk factors would be the possible constraints of the individual to respond to the questionnaire. However, the broader understanding of the professional health / patient relationship, especially in the case of patients under stigmatising conditions, can be seen with one of the main contributions of this study.

The study was approved by the Comitê de Ética em Pesquisa da Universidade Federal de Pernambuco-CEP/UFPE (Research Ethics Committee of the Federal University of Pernambuco) and respected the ethical aspects in force, according to the Resolução do Conselho Nacional de Saúde (CNS) 466/2012 (Resolution of the National Health Council) [8]. Participants signed a informed consent form for human research.

Results

The sample consisted of 67 individuals, 38 men and 29 women, the prevalent age range being

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40 to 62 years (55.2%). As to sexual orientation, the majority were heterosexual, followed by homosexuals and bisexuals (Table 1).

Table 1. Participants by age group, gender and sexual orientation. Recife, Brasil, 2014

	n	%
Age (years)		
Up to 39	27	40.3
40 to 62	37	55.2
Not in the system	3	4.5
Sex		
Male	38	57
Female	29	43
Sexual orientation		
Heterossexual	38	56.7
Homossexual	20	29.8
Bissexual	3	4.5
Not in the system	6	9
Total	**67**	**100**

Based on the data, 90% of those surveyed had already had at least one dentist visit. After positive diagnosis for the disease, the percentage of visits to the dentist dropped to 84%. The reasons for the withdrawal were varied: 25% were afraid of the dentist's reaction; 10% did not want to reveal their diagnosis to anyone and 4.5% were afraid that the professional would associate the disease with homosexuality.

Patients who omitted to tell the dentist about their seropositivity corresponded to 31%, in contrast to the 60% who reported the diagnosis. Of these, 31% reported changes in the professional's attitude. When questioned about the likely reason for this, 20% attributed the behaviour change to lack of information and / or prejudice of the dentist and 7% to fear of contamination by the virus.

It was observed that 27% of the participants already experienced some type of discrimination on the part of the professional. As a result, 57% believe that concealing the disease from the dentist is the best way to ensure treatment. Even with the cases of omission, the majority of patients (78%) considered it important to inform the professional about the diagnosis.

After confirming the seropositivity in the anamnesis, the experience of denying dental treatment was reported by 22% of the respondents. Faced with the negative reaction, 51% believe that dentists are less willing to treat patients.

Table 2. Behaviour and patient / dentist relationship. Recife, 2014

	n	%
Have you ever felt discriminated against by dentists?		
Yes	18	27
No	40	60
Not in the system	9	13
Tp avoid telling the dentist that you are HIV positive, in your opinion, ensures that the treatment will be performed?		
Yes	38	57
No	24	36
Not in the system	5	7
Do you think it is necessary to tell the dentist that you have HIV / AIDS?		
Yes	52	78
No	15	22
Total	**67**	**100**

Table 3. Behaviour of the dentist and refusal of treatment

	n	%
Have you stopped receiving dental treatment after reporting that you have HIV / AIDS?		
Yes	15	22
No	34	51
Not in the system	18	27
Do you think dentists usually treat HIV-positive patients?		
Yes	18	27
No	28	42
Sometimes	6	9
I don't know	3	4
Not in the system	12	18
Why do you think there is a change in the way of care?		
Prejudice	22	33
Lack of information of the professional	7	10
Lack of love of the profession	2	3
Fear of what other patients will think	1	1.5
Attend well only in reference units	1	1.5
Not in the system	34	51
Total	**67**	**100**

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Discussion

The epidemiological profile of the virus carriers has undergone important changes over the years, following the dynamics of society's behaviour and culture. The old equation of HIV infection, related to risk groups and their culpability, gave way to a picture with strong traces of ageing, heterosexualisation and feminisation [9]. However, the initial stereotype of young, lean, homosexual men may still persist in the collective imaginary, facilitating the non-adoption of preventive measures of those who don't share this profile.

The "ageing" of the epidemic suggests several factors: changes in the sexual behaviour of the elderly; increased unprotected sexual activity, underestimating the risks of infection at advanced ages; effectiveness of antiretroviral therapies and longer life expectancy [10]. In 2010, the age group between 40 and 49 years old had the highest proportion of cases reported by the Sistemas de Informação de Saúde (Health Information Systems) (24.8%). In 2011, the age group with the highest incidence rate was 35 to 39 years. Another important data refers to the period between 1998 and 2010, when adult AIDS cases increased in the 50-59 age group or older [11,12]. Corroborating these statistics, the sample of the present research was composed mostly (55.2%) by individuals of more advanced age (between 40 and 62 years).

The analysis showed a heterosexualisation character consistent with the new design of the disease dissemination, with predominance of heterosexuals (57%). It has been observed that the tendency to associate HIV with homosexuals has been overpast with this reconstruction of the infected person's profile. Between 1998 and 2010, there was a 12% increase in cases involving heterosexual male subjects, 13 years of age or older. On the other hand, the rate of homosexuals contaminated in the same period fell from 31.1% to 29.7% [11,12].

The ratio between infected male and female has been declining over the decades. In 1985, for every 26 cases among men, there were one among women. In 2010, this ratio varied to 1.7 men for each woman. It is worth mentioning that, between 2000 and 2005, there was a reversal: 0.9 cases among men for each woman [11,13]. Increased virus transmission through heterosexual intercourse has contributed to the increasing number of cases in women. Female contamination through this route represents more than 75% of cases of AIDS [14].

A study by Santos et al [15] also defended the association between heterosexualisation and the strong feminisation of the new epidemiological profile. Following this trend, the sample of the present article showed a subtle difference between the percentage of men and women. Clearly, the prevalence of infected men gave way to gender balance over time.

Patients with HIV who are unsure about the dentist's reaction are the portrayal of treatment withdrawal, low demand for care or omission of information during the anamnesis. The negative social representation of the disease reflects both in the introversion of the patient and in inadequate behaviours of unprepared dentists. In the health area, denial of care, exaggerated biosafety protocols, and/or breach of medical history are examples of discriminatory practices [16].

Among the subjects studied, the main reasons for giving up dental treatment after confirmation of infection were fear of the dentist's reaction (25%); fear of lack of discretion of the diagnosis by the care team (10%); concern caused by prior judgment on the mode of contamination (4.5%). The findings, therefore, reinforce data from other studies [4,6,7,17] and reveal how dental care can be compromised by the anguish of suffering prejudice.

The unpreparedness of dentistry professionals in the field of human relations, especially in relation to acceptance and respect for diversities, seems to distance patients. This observation reinforces the urgent need to stimulate humanisation in academic training so that health professionals can effectively meet the needs of patients.

A discrimination index of 27% was found, comparatively lower than some studies already reported [4,17], but still significant. In the analysis by Garbin et al. [17], whose sample was composed of 69 HIV/AIDS carriers in the city of Três Lagoas (Mato Grosso do Sul, Brazil), more than 49% of the participants reported a history of discrimination by a health professional. In the study by Lelis *et al* [4], the percentage of similar cases was also high – greater than or equal to 40% – being attributed to nurses, dentists and physicians. Discriminatory practices of professionals with HIV / AIDS patients reported in both studies [4,17] follow the findings of the present study: denial or resistance to dental care, physical

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isolation or any other type of differential treatment to the patient.

Importantly, regardless of statistical variations, there is a considerable amount of prejudice against virus carriers and this may lead them to omit the diagnosis as a defense mechanism. For this reason, more than 55% of the participants in this study stated that hiding the seropositivity from the dentist during the anamnesis questionnaire is the best way of guaranteeing the treatment (One usually asks: "Have you ever had an HIV test? What is the result?").

This statistic is worrying, since ensuring care based on this omission can create a cycle capable of compromising the integrality of care and its effectiveness. There is talk of qualitative loss of care because some oral pathologies are directly associated with the virus. If the dentist does not know the patient's systemic condition, the cohesion of the team that accompanies the individual may be affected, and the treatment may be fragmented. Therefore, the user's complete medical history is critical to the best follow up. From the dentist, it is expected that the diagnosis of AIDS will not be seen as an alert for excessive care, since biosafety protocols always guide the professional to consider every patient as potentially infected [7].

More than 50% of those surveyed had the perception that dentists became less willing to attend to them after they learned about their seropositivity,. The possible reasons suggested for the change in their behaviour were lack of professional information (20%) and fear of contamination (7%).

These results are supported by Senna, Guimarães and Pordeus [18], who evaluated the willingness of dentists to treat seropositive patients in Belo Horizonte (Minas Gerais, Brazil). The analysis observed positive behaviours of the most enlightened dentists regarding the risks of contamination and protocols of accidental exposure. On the other hand, there was a lower disposition of professionals with a history of sharps injuries, even though the risk of percutaneous infection with contaminated blood (0.3%) was minimal [19]. Thus, the level of professional knowledge and the probability of accidents with contaminated biological material appear to have a direct influence on how HIV-positive patients are treated in the office.

Feltrin, Navarro and Sposto [20] found that, despite the greater knowledge of the scientific community on the disease, the opinion of many professionals still remained in insecurity and misinformation. Their research involved 265 dentists and the results were alarming: more than 5% of respondents considered injecting drug users as the most affected risk group and 18.3% considered homosexual men to be the most infected group. In addition, they found that more than 50% of dentists would not attend patients if they knew about the positive serology.

Comparing the reality of 1997 diagnosed by Feltrin, Navarro and Sposto [20] to the present day, this work shows that public opinion, although still discriminatory, is more flexible. According to 33% of the respondents at the Gesos NGO, the prejudice of the dentist is the main factor for the change in the form of care after being informed of the condition of seropositivity. The figures show that the acquired technical knowledge about the disease over the years is not enough to transform the professional's discriminatory behaviour.

Excessive biosecurity and individual accountability are strong indications of the discrimination suggested by the participants, data also shared by the study by Jovic-Vranes *et al.* [21]. The study's statistics revealed that more than 80% of the professionals used additional individual protection in the care of seropositive individuals and that 5% blamed the carrier for the infection. In addition, it pointed the dental surgeons as the class more concerned with the risk of infection.

Although omission of positive serology has been reported, most carriers (78%) said they felt it necessary to inform the dentist. This awareness demonstrates the understanding of the importance of reporting health condition to the professional; however, in the face of the dilemma between the possibility of having the service refused and the risk of some complication due to the omission, some patients prefer to take the risk. It is also plausible to perceive the risk of occupational exposure involving dentists, as well as other health professionals who manipulate body fluids and piercing/sharp materials In the medical category, dental surgeons has are the second profession most affected by accidents of a biological nature [22].

Although the lack of theoretical knowledge on AIDS is responsible for the rejection of seropositive patients, another critical factor is also part of this scenario: vulnerability. According to Czeresnia and Freitas [23], the vulnerability principle considers the

chance of exposing people to risk and illness as a result of several aspects, not just individual ones. It is influenced by three axes: the individual, the social and the programmatic component.

The first concerns the level of information that the individual has about the problem, the way in which they interpret the information and the possibility of incorporating the information into their daily practices. The social component analyses how this individual can be influenced by sociopolitical, media, and cultural aspects of today's society. Finally, the component deals with resources for prevention and protection of individuals from public policies at the regional and national levels. In bringing these concepts into the context of the present work, it is perceived that adopting new postures is something quite complex and does not depend exclusively on the individual aspect - here symbolised by the knowledge that each professional has about the virus and his or her ability to incorporate new attitudes to the day to day.

Behavioural dynamics and its tangle of modifying factors find investigations [24-26] in the literature that harmonise with the theory of Czeresnia and Freitas [23]. Oliveira and collaborators [24] conducted research with young people between 14 and 22 years old on forms of prevention of sexually transmitted diseases (STD) and the adoption of means of protection. The results showed divergence between theory and practice: even though they knew about it, they continued to expose themselves to the risk of contamination.

Guerriero, Ayres and Hearst [25] found a similar situation: all the participants in the research knew about AIDS and the condom as a form of prevention, but none said to use it to protect themselves in daily life. In addition, the justifications indicated thoughts of invulnerability to virus infection. Fernandes et al [26] also found conflicting data when they observed that 77.2% of the sample knew the forms of HIV prevention and the importance of condom use, but more than 72% were not using it.

It is essential to understand that the subject must overcome obstacles that go beyond the individual sphere - especially the cultural ones - to be able to digest the acquired theory and apply it in life. Health professionals are also part of the social process of contextualising the disease, and sometimes the clarification on the subject may not be sufficient to guide the conduct, resulting in inadequate care and infractions of the precepts of the Código de Ética Odontológica – CEO (Code of Ethical Dentistry) [27].

Final considerations

It is undeniable that the initial context of disinformation and longing for clarification about the new epidemic resulted in the search for answers and prevention methods that only ceased when "risk groups" were characterised as actors in the AIDS phenomenon. The stigmatising discourse at the time was so widespread that it still remains rooted in Brazilian culture.

This study found that the findings about HIV over the years were unable to dissolve the prejudice and stigma that affect HIV-positive people, since many of them still feel discriminated against in health care services, especially in those that are not specifically focused on care of people with AIDS. The insecurity and the fear pointed out in the present study are reflections of the discrimination still present both in the formation and professional life of the dentists as in the area of health in general FORM.

Therefore, it is necessary for the professional to be informed about the disease and to actively work on their behaviour and emotional views, so that the knowledge acquired is truly introjected and put into practice. In addition, it is essential to foster the humanisation of the patient-professional relationship and to establish bonds that promote the psychosocial well-being and the quality of life of HIV carriers.

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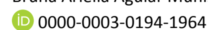
Participation of the Author's

Diene Carvalho Belo da Fonte collected the data and performed the statistical analysis. Bruna Ariella Aguiar Muniz interpreted the results and wrote the article. Saulo Cabral dos Santos guided the research and did the critical review of the work.

Bruna Ariella Aguiar Muniz

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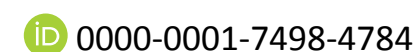
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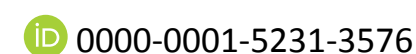
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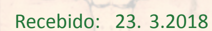

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Research