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Burnout, Stress, and Wellbeing: The Rising Mental Health Crisis in UK Dentistry in Dental Care Professionals. A Quantitative Perspective

Jenny Durkin[1] | Ceris Mumford[2]

[1]School of Medicine and Dentistry, University of Central Lancashire, Lancashire, UK | [2]Faculty of Arts, Society and Professional Studies, Birmingham Newman University, Birmingham, UK

Correspondence: Jenny Durkin (jdurkin1@uclan.ac.uk)

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ABSTRACT

Research Aim: To determine if dental care professionals working in National Health Service (NHS) practices are more at risk of stress, wellbeing concerns and burnout than their private practice counterparts.

Introduction: In dentistry, stress, anxiety, and wellbeing concerns have been apparent for many years with burnout and poor mental health in dental registrants being described as early as the 1980s.

Methodology: An online platform-based questionnaire was used to administer the chosen scales. Data from 201 participants were analysed ($N = 201$). The sample consisted of 31 dental nurses and 170 dental hygienists and dental therapists.

Results and Conclusions: A one-way multivariate analysis of variance (MANOVA) determined that there was no statistically significant difference between private and mixed practice dental professionals on the combined scales $F(3, 190) = 0.76$, $p = 0.59$, Wilks Lambda = 0.97, partial eta squared = 0.12. Dental hygienists, dental therapists and dental nurses working in mixed private and NHS dentistry are not more susceptible to stress, wellbeing issues and anxiety than their private counterparts according to the data set. This suggests that there are other factors associated in the mental health concerns of registered dental care professionals raised by the literature examined. The feelings and frustrations of dental registrants are likely to have lasting consequences for the provision of dentistry if working practices and hierarchical conditions do not improve patient access to both private and NHS dentistry. More research into the stress, wellbeing and burnout levels across dental registrants would be beneficial to explore the effects on the entire dental team, with a focus on solely working in NHS provision.

1 | Introduction

The problem of stress, burnout and wellbeing has been apparent for almost the last 40 years in dentistry [1, 2] with seemingly very little done to change the working practices of the dental profession. A statement reaffirmed by a 2022 study on occupational stress in dentistry in China [3]. Previously, investigations have targeted the occupational effects of stress in general dentists [2, 4–8], but there has been little research on other registrants of the General Dental Council in the United Kingdom. Much of the focus of the research conducted on general dentists has investigated coping strategies, measured using semi structured interviews. Results indicated that dentists found appearing to be calm and in control was one of the most stressful parts of their role. Due to the nature of patient anxiety, the pressure of ensuring patients felt calm and reassured was often leaving dentists feeling anxious and frustrated themselves. Other research [7] demonstrates that dentists are more prone to work related stress than dental care professionals (DCPs) and provides a link to increased stress when working within the NHS. This aligned with

Summary

- Clinical relevance
  - The wellbeing of dental professionals and the ability to fill roles to provide dental care to the public.
- Scientific rationale for the study
  - Very little research on the state of dentistry in the United Kingdom has focused on the providers, and this is now the next necessary population to consider while the government debates how to salvage NHS dentistry.
- Principle findings
  - There was no statistically significant difference between private and mixed practice dental professionals on the combined scales. Dental hygienists, dental therapists and dental nurses working in mixed NHS dentistry are not more susceptible to stress, wellbeing issues and anxiety than their private counterparts according to the data set. More research is required to look at the potential occupational coccncerns for dental personnel.
- Practical implications
  - With dentistry under the spotlight for lack of access, its important to consider the reasons for lack of interest in entering or staying within the field, thereby addressing the problem of filling NHS positions.

earlier work [9] that found the size of the dental practice, number of days working clinically each week and the proportion of NHS work undertaken were risk factors for burnout in dentists. A sample of dentists surveyed who were asked if they would still follow the same career trajectory, with the knowledge they have now, revealed that 67% of respondents would not have pursued dentistry as a career [10].

There have been studies on the mental health of dentists since the 1980s [1, 2, 7, 11]. A paper published in 1987 predicted future health and wellbeing concerns if stress and methods of practice were not developed [2]. More recent data suggests the same issues have been demonstrated in the last 10 years [4, 5, 7, 12–14], and that this is now influencing recruitment of dentists: 75% of NHS dental practices are unable to fill vacancies [15] mainly due to retirement and the intention of newly qualified personnel not to work in the NHS system. There has even been some suggestion that dental professionals working as dentists have felt so overwhelmed they have considered suicide [8]. In January 2020, 23,733 dentists were providing NHS care, 2 years later, in January 2022, this had reduced to 21,544 [16]. Since private high street dentistry was responsible for more than £8.5 billion in profit for the fiscal year of 2019 [17], it is quite possible that general dental practitioners are looking to alternative working patterns outside of the NHS system. As much of the research conducted has focused solely on dentists, the current research proposed to look at other dental registrants who may be experiencing similar concerns with their stress, wellbeing and burnout.

This work presented is consistent with much of the research conducted in this field on dentists, with existing scales on burnout, wellbeing and stress levels being used alongside constructed questions specific to the required data set. Existing scales provide the advantage of having been tried and tested and the use of several scales gives a better and bigger picture of the issues involved [18]. By targeting a wider participant base and focusing on dental therapists, dental hygienists and dental nurses, it is hoped to establish whether stress is also affecting other dental care professionals.

1.1 | Aims

To determine if dental hygienists, therapists, and dental nurses (DCPs) working in NHS practices were more at risk of stress, wellbeing concerns and burnout than those working in mixed NHS and private general practice.

2 | Materials and Methods

This research adheres to guidelines in the Declaration of Helsinki [19] with these protocols being followed to ensure that participants gave informed, written consent, and were made aware of their rights as research participants, before participating in this research.

Participants accessed an online platform-based questionnaire via Questionpro. After reading the participant information sheet and signing the consent form demographic details were completed that is; their job title, years in practice, whether NHS or private, gender, and age. The questionnaire took on average 10 min to complete. Three established scales were used to assess stress levels, presented in the following order: the Perceived Stress Scale (PSS-10) [1]; the World Health Organisation (WHO-5) wellbeing Index [20]; and the Copenhagen Burnout Inventory [21] (CBI). These scales were chosen based on their reliability and validity; they were also freely available. Cohen and Williamson [1] reported that scores on the PSS-10 demonstrated adequate internal consistency reliability ($\alpha = 0.78$), and suggested it was superior to the earlier 14-point version devised in 1983, which is why it was chosen for this study. Topp et al. [20] reviewed the WHO-5 and found it to be both sensitive and specific as a screening tool for depression and reported high clinometric validity from a systematic review of over 200 papers. Piperac et al. [22] reported a Cronbach's alpha for the Copenhagen Burnout Inventory (CBI) as an overall scale of 0.936, indicating that responses were consistent and reliable and in turn concurrently valid. Following data collection, factors such as type of practice (NHS, private, or mixed); and job titles were explored using a one-way MANOVA between subjects.

2.1 | Participants

Participants ($N = 255$) were recruited using opportunity sampling. Registered dental therapists, hygienists and dental nurses were invited to participate via personal email address or through online groups, having obtained group administrator consent. There were 210 respondents who fully completed the surveys; 10 male (4.8%) and 200 (95.2%) female, aged 22–63 (mean age = 39.4) with a mean of 8.73 years in practice (based on data provided by 208 respondents). All were currently on the General Dental Council (GDC) register, working in general

practice. Following removal of outliers (due to working outside of the United Kingdom), data from 201 participants were analysed; 1 was male (2%), 200 were female (98%). The sample consisted of 31 dental nurses and 170 dental hygienists or therapists. Eighty-four worked in exclusively private practice: 14 exclusively in NHS practice, and 103 in mixed practices.

Considering Green's rule of thumb [23] and the maximum number of independent variables for the quantitative element being three, a sample of 174 participants was deemed necessary for MANOVA analysis. A Gpower analysis was conducted and based on Pillai-bartlett V of 0.06 medium effect, and a power of 0.8 in line with Cohen's guidelines [24], it was determined that for a one-way MANOVA between subjects with two groups and three dependent variables, a sample size of 180 was necessary.

2.2 | Ethical Considerations

After reading the Participant Information Sheet provided and having the opportunity to ask questions, participants completed a consent form. Each participant was allocated a participant number should they wish to withdraw, which they were able to do at any point until 2 weeks after data collection was complete. A debrief sheet was also provided to participants, signposting available supportshould they feel that it was required. For the purposes of General Data Protection Regulations (GDPR), once the research was complete, any identifying participant information, including email addresses, were deleted. Ethical clearance was provided by Newman University for the research project to be conducted, and the participant information sheets were provided as part of the approvals process.

Participants were recruited via social media and personal connections; no requests to participate were made via the investigator's places of study or work, or via NHS channels.

3 | Results

3.1 | Quantitative Data Set

A total of 255 respondents replied to posts on social media asking for participants; Ten were remove due to working internationally, and 44 did not complete the questionnaire in each category. Their data were removed from the dataset and data ($N = 201$) were exported into SPSS for analysis.

3.2 | Descriptive Statistics

A total of 201 respondents were included in the dataset for analysis aged between 22 and 63 (mean age = 39.8 years, SD = 10.2). Ten respondents (4.8%) identified as male, and 200 (95.2%) identified as female. All participants reported how many years they had been in practice (Mean = 8.73 years, SD = 2.4).

Data associated with age and years and job title in practice were discounted for the analysis due to the low numbers of participants in each interval. This was necessary as in some cases the number of dependant variables was greater than the number of respondents within the age groups and years of service [25].

Respondents' place of work in terms of private, NHS or mixed practices is defined in Table 1, with 58% of respondents working in mixed NHS and private dentistry compared with 42% in a solely private capacity. For the analysis, the NHS and mixed practices were combined, the sample size was therefore deemed acceptable for analysis ($N = 201$).

According to Kristensen's criteria [21] of burnout levels on the Copenhagen burnout inventory, moderate levels of burnout would score between 50 and 74. Figure 1 presents the mean CBI scores for each job role and each type of practice.

From Figure 1 it is apparent that most respondents scored moderately, with NHS dental therapists and hygienists scoring on the higher end of the spectrum in their profession. This indicates fairly high levels of burnout across the mixed NHS dental hygienists and therapists. However, the graph also indicates that dental nurses working in private practice had the highest average scores.

Figure 2 shows the distribution of responses for the WHO-5 scale. The mean scores are represented in the bar chart, with 0 being worst possible life quality and 25 being best possible. It is apparent from the graph that private dental nurses had the lowest scores (mean = 18.11).

Figure 3 shows the distribution of responses for the PSS10 scale, with 40 representing the highest level of stress. The results indicate dental therapists and hygienists working in private dentistry and mixed practices are closely matched in terms of their stress levels, with dental nurses in both private and NHS categories being closely matched as well. The data suggests the type of dentistry being practised has little bearing on the stress levels regardless of job role.

Analysis for multivariate normality was calculated using Mahalanobis distance, considering the maximum value for each dependent variable against the critical value of 16.27 [25]. There was no data present above the critical value, maintaining the sample size at 201. This number is acceptable in accordance with the Gpower analysis (which identified a required sample of 190 participants) and based on Pillai-bartlett V of 0.06 medium effect and a power of 0.8 in line with Cohen [24] for a one-way MANOVA.

TABLE 1 | The percentage of respondents working in private, NHS and mixed dental practices.

Type of practice	Frequency	Percent
Private	84	42
NHS	14	7
Mixed	103	51
Total	201	100

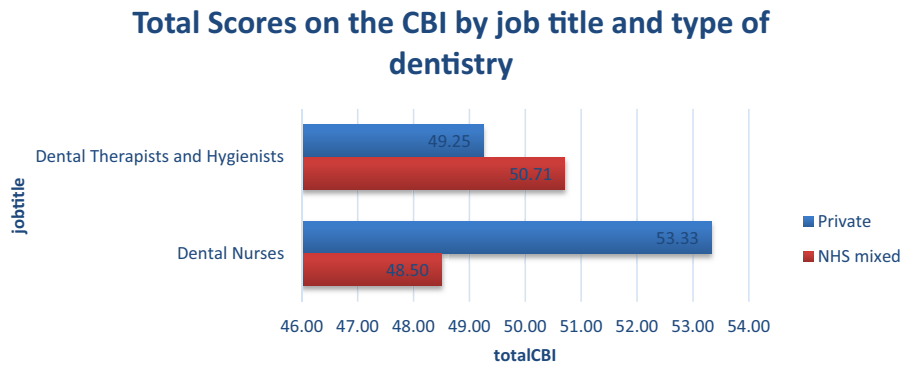

FIGURE 1 | Total scores on the CBI by job title and type of dentistry. Shows respondents answers to the copenhagen burnout Inventory. Moderate levels of burnout would score between 50 and 74.

3.3 | Correlations Between Scales

The correlation coefficients were investigated using a Pearson product moment correlation coefficient [25] to determine if there was a mutual relationship between each of the three scales. Preliminary analyses were performed to determine there was no chance of violation of the assumptions of normality and linearity [25]. There was a moderate negative correlation between the CBI () and the WHO-5 scale ($r = -0.61$, $n = 201$, $p < 0.001$)

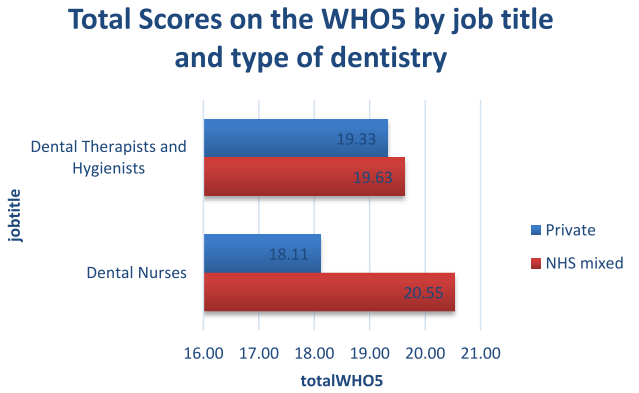

FIGURE 2 | Total scores on the WHO5 scale by job title and type of dentistry, with 0 representing the worst possible quality of life and 25 representing the best possible.

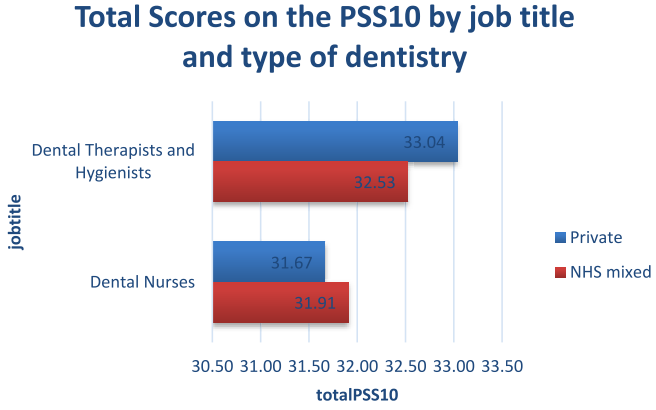

FIGURE 3 | Total scores on the PSS10 scale by job title and type of dentistry. A score of 40 represents the highest level of stress, and 0 the lowest.

suggesting that the better the wellbeing of the respondent, the less burned out they feel. However a shared variance of 37%, indicates that improved wellbeing only overlaps with a small proportion of the results.

There was a medium positive correlation between the CBI and the PSS10 scale ($r = 0.49$, $n = 201$, $p > 0.001$) suggesting the more stressed a respondent is, the more burnout they experience; however, this result was not statistically significant. The shared variance between the two scales was 24%, indicating 76% of the scores did not overlap. In terms of the PSS10 and the Who-5, there was a small negative correlation, but with no statistical significance and a shared variance of less than 2%, indicating that only 2% of the variables overlap ($r = -0.15$, $n = 201$, $p > 0.001$).

3.4 | One-Way MANOVA Results

A one-way multivariate analysis of variance was performed to investigate whether working for private or mixed private and NHS practices significantly impacted stress, wellbeing, and burnout in dental professionals. Initial analysis of individual scales suggests that dental professionals scored highly for stress, on the PSS-10 scale.

The independent variable was private versus mixed and NHS dental practices. Preliminary assumption testing was conducted to check for outliers, normality, linearity, equality of variance (Levenes figures > 0.5) and homogeneity of variance–covariance (Box's M = 35.79), no serious violations were noted, and significant outliers had already beenremoved from the data set [26].

There was no statistically significant difference between private, and NHS and mixed practice dental professionals F (3, 190) = 0.76, $p = 0.59$, Wilks Lambda = 0.97, partial eta squared = 0.12. A Bonferonni adjustment was applied [24, 27] prior to consideration of each dependent variable and confirmed there was no significant difference in dental practice experience. When considering the effect size the proportion of the variance explained by the type of practice worked in, has a small effect, as the partial eta squared indicates only 1.2% of the results can be attributed to private or NHS dentistry [1].

Due to the uneven sample size and the combination of the mixed and NHS category, data was bootstrapped [25] to

estimate the population distribution should the samples have been more even. The bootstrapped data yielded findings that the standard error of estimates was very close to those obtained using the classical MANOVA approach, indicating that the model provides a good fit for the data. Also, considering the sample sizes and that the data potentially violates the assumptions (as confirmed by table 4, unequal SD across the scales with PSS = 4.89, who = 11.89 and Copenhagen = 4.94), a Kruskal Wallis H analysis was considered for each of the scales.

Results indicate that there is a 70% chance of finding the results reported for the PSS10 scale through random sampling. The study does not demonstrate private, mixed or NHS dentistry as causative for stress, wellbeing, and anxiety through the PSS scale $H(2) = 0.723$, $p = 0.7$. Similar results are yielded for the WHO scale $H(2) = 4.3$, $p = 0.12$. The Copenhagen inventory however, showed statistically significant findings, for types of dentistry performed and the likely stress, anxiety, and wellbeing concerns $H(2) = 6.1$, $p = 0.05$.

4 | Discussion

The aims of the study were to determine how susceptible dental care professionals were to stress, wellbeing issues and burnout. Using a quantitative approach, data were collected and analysed. Dental hygienists and therapists in private practice completing the PSS10 had higher stress levels than their counterparts in NHS mixed practices. For wellbeing, dental nurses scored as having a much lower quality of life than dental hygienists and therapists on the Who-5 scale. For burnout, dental hygienists and therapists scored higher on the Copenhagen inventory than dental nurses.

In summary, the findings support the cited research [1, 9, 11, 28, 29] and suggest that predictions of future health and wellbeing concerns made in the 80s were accurate [2]. A more longitudinal capturing of data and inclusion of all dental professionals on the General Dental Council Register would be beneficial in answering the further questions the current study has raised and gives scope for further investigation into the subject matter, including addressing the issue of retention of dental staff in general dental practices.

Limitations of the study include a lack of dental nurse respondents, which could easily have skewed the results. Advertisements were placed on dental Facebook forums and the number of respondents was much higher for private and mixed dental therapists and dental hygienists. A more diverse participant group would have given a more accurate result for the analysis. Also, because most respondents worked in a mixed setting, and not solely NHS, this area would benefit from a continuation of the research to enable a more favourable sample size to consider the constraints of working only within the NHS contract. Other factors that had to be dismissed due to lack of numbers included gender, age, and years in practice. For this reason, there are definite limitations to the quantitative element of the work that, if replicated, would need to be addressed. With a bigger participant pool and adopting a longitudinal approach, a more rounded picture from registrants of different genders and geographical locations may show a greater difference between NHS and private practice and the problems associated. There is also scope to consider if roles within dentistry and other variables may impact women differently to their male counterparts. Further study of these issues would be beneficial to really break down the issues further and plan for changes that would make a meaningful difference to dental personnel, especially considering the current agenda for change and required overhaul of dentistry provision [30].

5 | Conclusion

It is apparent that currently there are issues within dentistry for dental therapists, hygienists and dental nurses [7, 31, 32], which are likely to have lasting consequences for the provision of dentistry. While there was little evidence to suggest that the morale of the participants of the current study was low enough for them to consider hurting themselves, as another study reported [8] there is certainly evidence to suggest that the current state of UK dentistry is cause for concern, as indicated by articles In the press detailing the difficulties practices are having retaining dentists [16] and the speculation on how sustainable the NHS dental system is [33, 34]. Although the participant pool was suboptimal due to a lack of responses from NHS based personnel and the need to incorporate registered dentists into the research, the message is clear. Change needs to come before it is too late!

Author Contributions

Both authors contributed to the study design. Jenny Durkin did the data collection, analysis and wrote the first draft of the manuscript. Both authors commented on previous versions of the manuscript. All authors approved the final manuscript.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Research data are not shared.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.