

Self-reported musculoskeletal symptoms among dentists in Saudi Arabia

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Abstract: Musculoskeletal disorders are very common in the dental practice. This cross-sectional study assessed the nature and prevalence of musculoskeletal symptoms (MS) and their associated risk factors among dentists in three types of clinics in Riyadh. A structured, self-administered questionnaire about demographic characteristics, nature of work, and prevalence and frequency of MS was completed by 274 male and 241 female dentists. Chi-square and logistic regression were used to determine the association of MS with a number of important variables. Pain in the lower back (64%) and neck (60%) were the most prevalent MS. Working in the dental colleges' clinics was associated with increased risk of MS (adjusted OR 2.30, 95% CI 1.27–4.18). A stronger association was observed for dentists working in the private clinics (adjusted OR 2.58, 95% CI 1.28–5.17) compared to government clinics. Female dentists were at more risk of MS than the male dentists (OR 1.63, 95% CI 1.02–2.59). The OR of MS for dentists treating more than 10 patients/d was 1.53 (95% CI 0.83–2.81). The higher risk of reported MS in females and for those working in the dental colleges and private clinics underscores the importance of recognition and prevention of MS even early in the dental profession.

Key words: Occupational hazards, Dentistry, Musculoskeletal disorders, Private Clinics, Safety training

Introduction

Dental profession and practice represents a unique occupation with regard to work demands and occupational hazards. Dentists normally work in restricted areas for extended hours in uncomfortable postures that require excessive use of vision, neck, back and hands¹. This can lead to discomfort, pain, strain and fatigue on muscles especially those of the neck and back thus contributing to increased prevalence of musculoskeletal symptoms (MS)^{2–3}. The high concentration and precision required in the dental practice places additional psychological stress which could exacerbate the effect of MS. Consequences of

MS can affect the general health and well-being of dentists and may contribute to days off work, reduction of work efficiency, or early retirement. The impact of this occupational health problem is quite high worldwide. A systematic review⁴ suggested that the prevalence of general musculoskeletal pain in dentists can range between 64% and 93%. According to World Health Organization (WHO), the burden of MS can be evaluated based on the pain and disability associated with the musculoskeletal system, and by investigating the causes such as trauma or joint disease⁵.

The majority of studies on work-related risks in dental workers were conducted in the developed world^{2, 6}. In developing countries, little attention awareness has been paid to the prevalence and effect of MS⁷. In particular, a few studies have been conducted in Saudi Arabia on health risks among dentists^{8–11}. In these studies, the risk factors of MS such as workload and years of experience were not

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examined. Risk factors are expected to be different in different types of dental clinics in Saudi Arabia. Therefore, it is crucial to estimate the prevalence of MS and identify the risk factors associated with their occurrence. This would help to develop recommendations and strategies for prevention.

Saudi Arabia has eighteen governmental dental colleges and six private colleges from which dentists graduate. Over the past 30 yr since the establishment of the first two dental schools in Saudi Arabia (at King Saud University Riyadh and at King Abdulaziz University Jeddah), there have been nearly equal percentages of men and women graduates¹². Dental students begin to practice in their third yr, when they start the clinical requirements. They usually have three d per wk of full-time clinical sessions in the university hospital¹³. Government dental clinics and a large number of private dental clinics operate in Saudi Arabia and provide a wide variety of dental services. They employ thousands of dentists, dental assistants and nurses¹³.

The main objective of the current cross-sectional study is to estimate the prevalence of MS symptoms, and investigate their risk factors in three types of clinics, namely: dental colleges, private and government clinics.

Methods

The study area and settings

The present study was carried out between June and October, 2015 on dentists working at government and private dental clinics as well as dental colleges in Riyadh city. All the dentists (Saudis and non-Saudis) in these types of clinics were eligible to participate. Since most of the dental clinics in Riyadh region operate in similar fashion, we believe that choosing clinics from different geographical areas in the city will achieve randomness. We used stratified random sampling process where administrative districts in Riyadh region were divided into four subgroups (North, South, East and West). The final list of both governmental and private clinics for the study were proportionally randomly selected from the four recruitment regions. This will ensure that all clinics in the city are represented in the sampling process. A total of 515 dentists participated in the study and the response rate was about 85%. Dentists who declined to participate stated that they were not interested as the main reason. Ethical approval was obtained from the Internal Review Board of King Abdulla International Medical Research Centre, King Saud Bin Saud University for Health Sciences-Grant# SP15-085. Each participating subject read and signed the informed consent form.

The questionnaire

A structured self-administered survey questionnaire was distributed to the participants who were given a short overview of the purpose and components of the questionnaire. The 28-item questionnaire took approximately 15 min to complete. The questionnaire contained three sections: (1) demographic variables, (2) work characteristics and (3) prevalence of MS symptoms. The last section focused on MS where respondents were asked to state whether or not they suffered MS symptoms during the past 12 months. If they answered yes, they were asked to identify body regions (neck, upper back, lower back, or hands/wrists) where they suffered from MS and to report the frequency of these symptoms (once or more than once).

Before embarking on the actual study, a pretesting phase was implemented in one randomly selected training center, Riyadh College of Dentistry. Five specialists in that center were asked to complete the survey and comment about simplicity, clarity and the length of the different sections. Most of the participants found the questionnaire clear and easy to follow, while only a few experienced some difficulties. The reported difficulties were related to clarity in some sentences and terms. The questionnaire was edited accordingly.

Data management and analysis

Data were entered and prepared for analysis by the SAS statistical software (SAS) version 9.4 (NC, USA). Frequency distribution of the different demographic characteristics (e.g. age, gender, years of experience), and work variables (nature of practice, type of education, working hours, the number of patients seen per day) were calculated in the three types of clinics. Chi-square tests were used to compare differences of the variables in the three clinics. Results with p -value of equal or less than α level of 0.05 were considered significant. A univariate logistic regression was performed to determine the association of neck and lower back MS symptoms with risk factors. These risk factors included demographic characteristics (age and gender), type of clinic, number of work hours, number of patients seen, experience years on the occurrence of neck and lower back MS symptoms. Multivariate logistic regression model was conducted by adjusting for age and gender and other variables that resulted in $p < 0.1$ in the univariate model. ORs with 95% CIs were calculated as measures of association between risk factors and MS. Selected age categories for analyses were similar to those reported in the previous studies, and also to reflect varying length of experience.

Table 1. Demographic characteristics of the study subjects

	Type of Clinic			All	<i>p</i> -value
	Dental colleges n=304 (59%)	Private n=112 (22%)	Government n=99 (19%)		
Gender					
Male	172 (57%)	61 (55%)	41 (41%)	274 (53%)	0.030
Female	132 (43%)	51 (45%)	58 (59%)	241 (47%)	
Age					
21–27	193 (63%)	15 (13%)	31 (31%)	239 (46%)	<0.0001
28–35	68 (23%)	61 (54%)	40 (40%)	170 (33%)	
36–45	26 (9%)	21 (19%)	22 (22%)	69 (13%)	
>45	16 (5%)	15 (13%)	6 (6%)	37 (7%)	
Professional status					
General Dentist	252 (82%)	70 (63%)	62 (63%)	384 (75%)	<0.00
Specialist	52 (18%)	42 (37%)	37 (37%)	131 (25%)	
Nationality					
Saudi	244 (80%)	11 (10%)	68 (68%)	323 (63%)	<0.00
Non-Saudi	60 (20%)	101 (90%)	31 (31%)	192 (37%)	
Practice years					
<5 yr	218 (73%)	30 (27%)	39 (40%)	287 (56%)	<0.00
5–10	40 (13%)	38 (34%)	30 (30%)	108 (20%)	
11–20	25 (8%)	32 (28%)	23 (23%)	80 (16%)	
>20	21 (7%)	12 (11%)	7 (7%)	40 (8%)	
Nature of practice					
Full time	245 (81%)	94 (84%)	91 (92%)	430 (84%)	0.31
Part time	59 (19%)	18 (16%)	8 (8%)	85 (16%)	
Type of Education					
Undergraduate	114 (38%)	13 (12%)	16 (16%)	143 (28%)	<0.00
Postgraduate	190 (62%)	99 (88%)	83 (84%)	372 (72%)	
Working hours					
<8	80 (26%)	28 (25%)	24 (24%)	132 (27%)	0.91
>8	224 (74%)	84 (84%)	75 (76%)	383 (74%)	
Number of patients/d					
<10	273 (90%)	42 (38%)	51 (52%)	366 (71%)	<0.001
11–20	28 (9%)	61 (54%)	34 (34%)	123 (24%)	
>20	3 (1%)	9 (8%)	14 (14%)	26 (5%)	

Results

Table 1 shows the demographic and work characteristics of the participants. As noted earlier, the study included 515 dentists, among them 53% ($n=274$) were male and 47% ($n=241$) were female. There was a significant difference in the percentages of subjects with different practice years between various types of clinics (p -value <0.0001). Although the majority (~75%) of dentists in the three types of clinics work for more than 8 h per d (p -value = 0.91), the number of patients seen per day was different among the three types of clinics (p <0.001) with 54% of the dentists seeing 11–20 patients per day compared to only 9% and 34% in dental colleges and governmental clinic, respectively.

Table 2. Prevalence and Frequency of MS in the past year

Body region	Prevalence N (%)	Frequency of occurrence	
		Once N (%)	More than once N (%)
Neck	302 (62%)	82 (27%)	220 (73%)
Wrist/Hands	229 (51%)	80 (35%)	149 (65%)
Upper back	239 (53%)	54 (23%)	185 (77%)
Lower back	228 (64%)	74 (26%)	214 (74%)

The prevalence of MS symptoms in the neck, wrist/hand, upper back and lower back in the past 12 months is shown in Table 2. The majority of dentists reported MS symptoms in the form of pain mainly in the lower back (64%), followed by neck pain (62%), upper back pain (53%), and then wrist/hand (51%). Pain occurring more

Table 3. Odds ratio of neck and back MS with different risk factors

Risk Factor	% with neck or lower back pain	OR (95% CI)	Adjusted OR* (95% CI)
Type of clinic			
Government	71	1.0	1.0
College	82	1.95 (1.57–3.30)	2.30 (1.27–4.18)
Private	86	2.49 (1.26–4.93)	2.58 (1.28–5.17)
Gender			
Male	78	1.0	1.0
Female	85	1.59 (1.01–2.49)	1.63 (1.02–2.59)
Work hours			
Less than 8	79	1.0	1.0
More than 8	81	1.13 (0.86–1.45)	1.10 (0.67–1.82)
Patients treated/d			
Less than 10	81	1.0	1.0
More than 10	82	1.32 (0.76–2.29)	1.53 (0.83–2.81)
Experience			
<5 yr	79	1.0	1.0
5–10	79	0.99 (0.57–1.72)	1.09 (0.56–2.10)
11–20	85	1.44 (0.73–2.84)	1.34 (0.53–3.40)
>20	85	1.44 (0.58–3.59)	0.95 (0.24–3.85)
Bending neck and back			
Yes	82	1.0	1.0
No	80	0.92 (0.57–1.48)	1.15 (0.70–1.88)
Age			
21–27	79	1.0	1.0
28–35	82	1.19 (0.72–1.96)	1.30 (0.73–2.33)
36–45	87	1.77 (0.82–3.82)	1.61 (0.56–4.61)
>45	78	0.96 (0.42–2.24)	0.62 (0.18–2.31)

* Adjusted by age, gender, and for each of the variables with $p < 0.10$ in the univariate model.

than once was reported by a large percentage of dentists: 77% for the upper back, 74% for the lower back, 73% for neck pain, and 65% for wrists/hands.

Table 3 shows logistic regression results for the risk of neck and back MS symptoms with different variables in both univariate and multivariate analysis. Multivariate analyses showed that students in the colleges' dental clinics have more than twice the risk of MS compared to dentists in the government clinics (OR 2.30, 95% CI (1.27–4.18)). There was a stronger association between MS and working the private clinics (adjusted OR 2.58, 95% CI 1.28–5.17). Females were significantly at increased risk of neck and lower back MS symptoms compared to males (adjusted OR 1.63, 95% CI 1.02–2.59). Dentists treating more than 10 patients had an OR of 1.53, 95% CI 0.83–2.81, after adjustment for factors in the multivariate model. The odds ratio of MS was 1.34, 95% CI 0.53–3.40 for those with practice years of 11–20. Bending of the neck or back when carrying out patient treatment was not associated with risk of neck and back MS symptoms (adjusted OR

1.15, 95% CI 0.70–1.88). Compared to the age of 21–27, those in the 28–35 age category had adjusted OR of 1.30 (95% CI 0.73–2.33), while dentists in the 36–45 age category had OR of 1.61, 95% CI 0.56–4.61. The OR in the univariate model for those over 45 yr was OR 0.96, 95% CI 0.42–2.24. Adjusting for confounders (age, gender, and for each of the variables alternatively) in the multivariate model showed a strong reduction in risk for this age group (OR 0.62, 95% CI 0.18–2.31).

Discussion

The nature of the dental practice work may position ergonomic hazards, the potential for trips, and slips, or the exposure to environmental factors in the workplace^{14, 15}. Consequently, dentists are predisposed to pain in many parts of the body depending on the location and the type of work they perform. The result of the current study showed high prevalence (64%) of lower back pain among dentists and dental students, followed by neck 62%, and upper back

pain 53%, then pain the wrist/hands (50%). This pattern was comparable to studies from Queensland Australia¹⁶, New Zealand¹⁷, and Saudi Arabia¹⁸. In another study in Saudi Arabia, the prevalence was even higher: 78% of overall MS, the highest site affected was lower back 73.5%, followed by the neck (66%) and the shoulders (43.3%)¹⁹. A study in Australia found a high prevalence of MS in dentists with more than 60% of them reported back pain²⁰. In an American study, 57% of 960 dentists in a dental society reported occasional back pain²¹. The reported prevalence of wrist/hands MS symptoms in the current study is higher than that reported in some previous studies. Ayers *et al.*²² showed that hand/wrist MS symptoms were reported in 22% of the female dentists.

The current results showing increased MS risk for dental students indicates that MS can appear early in the dental profession. In the USA, more than 70% of dental students reported pain in their third yr²³. A study in Turkey also reported high prevalence of pain among dental students: neck pain (67%) and back pain (56%) were the most common²⁴. Furthermore, back and neck pain was recorded at earlier stages than wrist complaints among Indian dentists²⁵. In a study of Lithuanian dentists²⁶, back pain (91.0%) was the most prevalent self-reported MS appearing at an early age. This effect was found to be statistically associated with negative health impact (OR: 0.41; 95% CI: 0.28–0.60). Altogether, these results show that most of the dentists used positions that regularly lead to MS of the low back and neck regions early in their career. Therefore, early recognition of MS during dental studies may contribute to early diagnosis and prevention, and contribute to implementation of ergonomics and occupational safety training programs in the dental practice.

The present study found an increased risk of MS when working in the private sector after adjusting for work hours and the number of patients treated. These results are in agreement with a recent study which showed an increased risk of MS with increased job demand of the private clinics²⁶. This may be attributed to the high workload encountered in private clinics. In private clinics, dentists treat larger number of patients per day and therefore may not have the time to take breaks or stretches. In addition, psychosocial stress resulting from higher job demand in private clinics may interact with physiological factors to increase the risk of MS.

The results showing increased risk in females conforms with the large body of the literature reporting the same finding^{27–29}. These results might have implications on the female productivity. It has been reported that more women

than men had taken ≥ 4 d off work due to illness in the preceding year and reported working ≥ 6 d when they felt unwell²². This can be attributed to the gender difference in muscular capacity. Not only women were more at risk of MS symptoms, but they were also more subject of bullying than their male counterparts²².

Two studies among dental practitioners of Saudi Arabia¹⁸ and New South Wales²⁰ showed that MS decrease with age and duration of the practice. Another study in Queensland, Australia² also showed that younger dentists who also have less experience reported more neck, upper back and shoulder pain. Authors of that study recognized that older dentists treat fewer patients per day. Another possible explanation is that more experienced dentists adopt corrective measures (e.g. improved position, exercise, and taking frequent rests) to avoid MS pains. The current results showing somewhat increased risk with 11–20 yr of experience (adjusted OR 1.34, 95% CI 0.53–3.40), and non-significant increased risk in the age groups of 28–35 and 36–45 (ORs 1.30 and 1.61, respectively). This can be attributed to increased workload. To some extent, especially in private clinics, dentists who have more experience usually treat more patients than senior dentists⁸.

The present study also showed somewhat increased risk of MS symptoms associated with treating more than 10 patients compared to treating less than 10 every day, but only slight increase in working more than 8 h per d. Unlike in other regions where daily working hours are correlated with increased work demand, in Saudi Arabia and in the government work in particular, more work hours do not necessarily mean increased workload (*personal communication with dental colleagues*).

Current results showed no difference in risk when bending neck and back during dental work. A previous study showed that the posture of the dentist during work that involves bending and twisting their neck causes neck and upper back pain, while bending over patient will lead to lower back pain³⁰.

This study has limitations. Firstly, information about weight and height of the dentists were not collected to obtain a body mass index (BMI). It is well-known that BMI is associated with back pain. Furthermore, Ayers *et al.*²² found that overweight dentists were more likely than those with a lower BMI to have experienced elbow, knee or ankle or foot pain in the previous 12 months. Secondly, particular dental activities associated with the different sites of MS (e.g. scaling treatment with neck pain or reaching for small instruments with hand/wrist pain)

were not investigated. This information could be useful in developing strategies to cope with MS during specific dental procedures. Thirdly, the severity of these conditions on overall health (e.g. proportion of dentists seeking medical attention or using pain medications) or their effect on work efficiency and impact on time off from work were not examined. Fourthly, because the study used cross-sectional design, the cause and effect cannot be established from the results. Other potential limitations include self-reporting bias, and lack of complete randomization. The former factor may lead to lack of precision on both the timing and the frequency of MS symptoms due to recall bias. The later factor may place some limits on the generalizability of the results.

Some of the strengths include the relatively large and varied sample that was collected from clinics at different locations in Riyadh city. This allowed for generalizability of the results. The current study also compared risk factors of MS in three types of clinics.

Conclusions

This study identified alarmingly high prevalence of MS symptoms especially in the neck and lower back, slightly higher than that reported in other studies. Dental students and dentists working in private clinics were reportedly more likely to develop MS symptoms compared to those in government clinics. Also female dentists were more likely to have MS than male dentists. Altogether, these results underscore the importance of early recognition, diagnosis and prevention of MS even for junior dental students. Awareness should be increased for female dentists and those working in dental clinics for the ergonomic hazards and control strategies, and of early recording of signs and symptoms of ergonomic concerns³¹. Other preventive measures may include taking sufficient rest during the day, doing some exercises, using correct body position while treating patients, purchasing ergonomically designed workstations, chairs, tools and equipment³².

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Contribution

Dr. Mustafa Al-Zoughool conceived the study and participated in its design and coordination, analyzed the data and drafted the manuscript.

Dr. Zainah Al-Shehri performed some the statistical analyses, conducted the questionnaire surveys and helped drafting the manuscripts.

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