

Attitudes of Adult Patients toward Chairside Screening for Medical Conditions in Dental Settings: A Hospital-Based Cross-Sectional Study in Peshawar

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Abstract

Background: The paradigm of healthcare delivery has shifted to emphasize holistic, integrated patient care. Dentists, as acknowledged by the World Health Organization (WHO), play a key role in systemic disease prevention and control. Non-communicable diseases (NCDs), including cardiovascular diseases (CVDs), diabetes, hepatitis B, and HIV/AIDS, are highly prevalent in Pakistan. Chairside medical screenings in dental settings could serve as a public health strategy for early detection of systemic diseases, yet patient attitudes toward these screenings remain understudied in Pakistan. The objective of the study was to assess patient attitude and willingness to chairside screening for systemic diseases in a hospital-based dental setting in Peshawar.

Methodology: A descriptive cross-sectional study was conducted at the dental outpatient department of Police Services Hospital, Peshawar, over six months from February to July 2025. A total of 420 patients aged 20 years and above were selected using consecutive sampling. Data were collected through a pretested structured questionnaire and analyzed using SPSS v22. Associations between demographic, socioeconomic factors, and willingness for screening were assessed through Chi-square, t-tests, and ANOVA and p value <0.05 was considered significant.

Results: The findings revealed significant associations ($p < 0.05$) between age, gender, education, employment, and willingness to undergo chairside screening. Women and younger participants were more willing, while educational attainment and employment status positively influenced acceptance. Socioeconomic disparities were evident, with lower willingness in economically disadvantaged groups.

Conclusion: The study highlights a generally positive attitude toward chairside screenings, with key demographic and socioeconomic factors influencing willingness. These insights can inform strategies to integrate chairside screening into routine dental visits, improving early detection and preventive healthcare in Pakistan.

Keywords: Chairside screening; patient perceptions; noncommunicable diseases; dental clinics; preventive health services; early diagnosis

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Introduction

In recent years, there has been a paradigm shift in healthcare, emphasizing a more holistic and integrated approach to patient care. The World Health Organization (WHO) has redefined the role of dentists, acknowledging their crucial contribution to the prevention and control of systemic diseases (1). This expanded role underscores the importance of incorporating medical screenings into routine dental visits, facilitating early detection, prevention, and intervention for systemic conditions alongside oral health assessments (2). Given the growing burden of non-communicable diseases (NCDs) in Pakistan including cardiovascular diseases (CVDs), diabetes mellitus (DM), hepatitis B, and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) early identification and risk assessment during dental visits can serve as a critical public health strategy (3).

NCDs account for approximately 77% of global age-standardized deaths, with CVDs alone responsible for nearly 30% of all fatalities worldwide (4). In Pakistan, diabetes prevalence has risen alarmingly to 11.77%, affecting 11.20% of males and 9.19% of females. Similarly, hepatitis B virus (HBV) affects 7–9 million people in the country, with a carrier rate of 3–5%. Although the overall



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HIV prevalence remains low at 0.1%, there has been an increase in transmission within high-risk populations, particularly in Khyber Pakhtunkhwa (5). The growing burden of these diseases highlights the necessity of incorporating screening measures into various healthcare settings, including dental clinics (6).

Several studies have demonstrated that chairside medical screening in dental settings can be an effective strategy to identify individuals who may not regularly visit primary healthcare providers (7). Research suggests that patients with underlying systemic conditions often exhibit oral manifestations, making dental visits an opportune moment for early disease detection. For instance, periodontitis is recognized as the sixth major complication of diabetes, with diabetic individuals twice as likely to experience attachment loss compared to non-diabetics (8). Similarly, dental infections have been linked to an increased risk of CVDs, emphasizing the importance of cardiovascular screening before dental procedures. Evidence suggests that targeted medical screenings at dental clinics could help identify at-risk individuals who may otherwise remain undiagnosed (9).

In Pakistan, although research on chairside medical screening in dental settings is limited, available evidence highlights growing professional support for integrating systemic disease screening into dental practice. A multicenter cross-sectional study conducted among dental professionals in Karachi found that a large majority of dentists expressed willingness to incorporate chairside screening for systemic non-communicable diseases such as diabetes and hypertension within routine dental practice, with over 89 % reporting readiness to participate in such screenings and 77 % willing to collect relevant biological samples for diagnostic purposes (10).

Despite the documented benefits, patient attitudes toward chairside screening remain a critical factor in the implementation of such initiatives. Some studies have reported positive acceptance, while others indicate hesitation due to concerns regarding privacy, feasibility, and the scope of dental practice.(11, 12) Additionally, studies evaluating dentists' willingness to conduct screenings have highlighted barriers such as inadequate training, time constraints, and perceived overstepping of professional boundaries. Understanding patient perspectives is essential to formulating effective policies and integrating chairside screenings into routine dental practice (13).

Given the public health significance and the rising prevalence of systemic diseases in Pakistan, there is a pressing need to explore patient attitudes toward chairside medical screening in dental settings. However, limited studies have been conducted on this subject in Pakistan. This study aims to bridge that gap by assessing patient perceptions, willingness, and potential barriers to chairside screening in a hospital-based dental setting in Peshawar. The findings may provide valuable insights for policymakers, healthcare professionals, and dental practitioners in enhancing preventive healthcare strategies and improving early disease detection.

Methodology

This descriptive cross-sectional study was conducted at the dental outpatient department of Police Services Hospital, Peshawar, over six months from the duration of February to July 2025. The study included male and female dental patients aged 20 years and above, while those unwilling to participate, mentally challenged, or previously diagnosed with medical conditions were excluded.

A total of 420 patients were selected using a consecutive sampling technique, with the sample size calculated via OpenEpi, considering a 50% anticipated positive attitude, 95% confidence level, 5% margin of error, and a 10% non-response rate.

Data were collected through a pretested, structured questionnaire translated into Urdu. The questionnaire consisted of three sections: demographic characteristics (age, gender, education, employment), socioeconomic characteristics (household members, assets, income sources), and a Likert-type scale assessing attitudes toward chairside screening for systemic diseases (cardiovascular diseases, diabetes, hepatitis B, HIV/AIDS). Responses were categorized as 1 strongly agree, 2 Agree, 3 Neutral, 4 Disagree, 5 Strongly disagree. This provide that "positive" (scores 1–2) or "negative" (scores 3–5).

Ethical approval was obtained from advanced studies and Research Board of Khyber Medical University (ASRB, KMU) and hospital administration. Data were analyzed using SPSS v22. Descriptive statistics (mean, SD, frequency, percentage) and inferential tests (Chi-square, t-test, ANOVA) assessed associations, considering $p < 0.05$ statistically significant.

Results

Demographic Characteristics of Study Participants

The demographic distribution of the study participants showed that the majority of respondents were aged 36–50 years 91 (42.9%) males and 104 (50.0%) females. Participants aged 50 years and above included 82 (38.7%) males and 50 (24.0%) females.

Regarding educational background, the highest proportion of participants had completed a bachelor's or master's degree, with 69 (32.5%) males and 30 (14.4%) females. Additionally, 119 (56.1%) males and 89 (42.8%) females had completed HSSC/Intermediate education, while a notable percentage of females (42 (20.2%)) had no formal education compared to only 3 (1.4%) males.

Employment status analysis revealed a higher employment ratio among males (143 (67.5%)) compared to females (77 (37.0%)) (Table 1).

Table 1: Demographic Characteristics of Study Participants Socio-Economic Distribution of Participants

Variables	Male (n, %)	Female (n, %)	p-value
Age Groups			0.004
20-35 years	39 (18.4%)	54 (26.0%)	
36-50 years	91 (42.9%)	104 (50.0%)	
>50 years	82 (38.7%)	50 (24.0%)	

Variables	Male (n, %)	Female (n, %)	p-value
Education Level			0.000
Nil	3 (1.4%)	42 (20.2%)	
Primary/Middle	13 (6.1%)	42 (20.2%)	
HSSC/Intermediate	119 (56.1%)	89 (42.8%)	
Bachelors/Masters	69 (32.5%)	30 (14.4%)	
Other	8 (3.8%)	5 (2.4%)	
Employment Status			0.000
Employed	143 (67.5%)	77 (37.0%)	
Unemployed	69 (32.5%)	131 (63.0%)	

Results showed that the socio-economic classification of the participants(14). Among the 420 study participants, the highest proportion was classified as chronically poor, 151 (36.0%), followed by extremely poor, 136 (32.4%), and transitory non-poor, 75 (17.9%). Notably, no participant was classified as non-poor, 0 (0.0%), reflecting the economic hardship within the study population (Table 2).

Table 2: Socio-Economic Distribution of Study Participants

Socio-Economic Status	Frequency (n)	Percentage (%)
Extremely poor	136	32.4
Chronically poor	151	36.0
Transitory poor	32	7.6
Transitory vulnerable	26	6.2
Transitory non-poor	75	17.9
Non-poor	0	0.0
Total	420	100.0

Association of Demographic and Socioeconomic Factors with Willingness for Screening & Testing

The results showed that the association between gender, education, employment, and age with willingness for different health screenings and tests. Significant differences were observed across all variables ($p < 0.05$). Women exhibited lower willingness for all types of screening compared to men. Educational attainment showed an inverse relationship with reluctance individuals with no formal education had the highest mean scores, indicating lower willingness, whereas those with a Master's degree were the most willing. Employment status also influenced willingness, with unemployed individuals showing lower mean scores compared to employed individuals. Additionally, younger individuals (<30 years) were more willing to undergo screenings than older participants (>50 years).

Table 3: Association of Gender, Education, Employment, and Age with Willingness for Screening & Testing

Variable	Mean Score (Chairside Screening)	Mean Score (Disease Screening)	Mean Score (Lab-Based Testing)	Mean Score (Height/Weight/BP)	p-value
Gender					
Male	1.76	2.06	1.64	2.08	0.0001
Female	2.19	2.43	2.49	2.33	0.0001
Education Level					
Nil	3.29	3.22	4.03	3.69	0.0001
Primary/Middle	3.27	3.61	3.98	3.55	0.0001

Variable	Mean Score (Chairside Screening)	Mean Score (Disease Screening)	Mean Score (Lab-Based Testing)	Mean Score (Height/Weight/BP)	p-value
Matric/Intermediate	2.35	2.41	2.59	2.44	0.001
Bachelor's Degree	1.65	1.70	1.75	1.69	0.0001
Master's Degree	1.00	1.10	1.64	1.48	0.0001
Employment Status					
Employed	1.45	2.38	1.72	2.01	0.001
Unemployed	2.55	2.72	2.68	2.69	0.001
Age Group					
<30 Years	1.89	2.12	1.84	2.17	0.013
30–50 Years	2.04	2.24	2.01	2.39	0.013
>50 Years	2.13	2.36	2.20	2.48	0.013

The association of socioeconomic status with willingness for screening and testing showed a clear trend emerged where individuals from lower economic backgrounds exhibited greater reluctance compared to wealthier individuals. The extremely poor group had the lowest mean scores across all screening categories, while the non-poor group consistently demonstrated the highest willingness. The findings underscore the role of financial stability in healthcare decision-making and highlight potential barriers to screening accessibility among lower-income populations. These results emphasize the need for targeted interventions to improve health screening acceptance among economically disadvantaged and less-educated populations (Table 4).

Table 4: Association of Socio-Economic Status with Willingness for Screening & Testing

Socio-Economic Status	Mean Score (Chairside Screening)	Mean Score (Disease Screening)	Mean Score (Lab-Based Testing)	Mean Score (Height/Weight/BP)	p-value
Extremely Poor	1.00	1.07	1.05	1.06	0.0001
Chronically Poor	2.11	2.45	2.34	2.39	0.0001
Transitory Poor	3.00	3.18	3.28	3.20	0.0001
Transitory Non-Poor	4.09	4.27	4.51	4.38	0.0001
Non-Poor	4.81	4.77	4.79	4.82	0.0001

Gender-based analysis shows that males exhibit a significantly higher willingness for medical screenings at dental clinics than females across all categories. The highest willingness among both genders is for cardiovascular disease and diabetes screenings. However, females are comparatively less inclined to undergo HIV/AIDS and laboratory-based screenings. All p-values indicate statistical significance ($p < 0.005$), demonstrating a meaningful difference in willingness between genders (Table 5).

Table 5: Gender-Based Willingness for Medical Screenings in Dental Clinics

Question	Response	Male (%)	Female (%)	p-value
Importance of dentist identifying medical risks	Positive	79.7	67.8	0.005
Cardiovascular disease screening	Positive	85.8	65.4	0.001
Diabetes mellitus screening	Positive	85.4	71.6	0.001
Hepatitis B screening	Positive	83.5	72.1	0.005
HIV/AIDS screening	Positive	82.1	61.1	0.001
Immediate chairside screening	Positive	85.8	74.5	0.004
Lab sample screening	Positive	76.9	63.5	0.003
Height & weight measurements	Positive	82.5	68.8	0.001
Blood pressure measurements	Positive	85.4	75.0	0.008
Blood sample collection	Positive	83.0	68.3	0.001

Table 6: Age-Based Willingness for Medical Screenings in Dental Clinics

Question	Response	20-35 Years (%)	36-50 Years (%)	>50 Years (%)	p-value
Importance of dentist identifying medical risks	Positive	83.9	72.8	68.2	0.028
Cardiovascular disease screening	Positive	81.7	76.9	69.7	0.045
Diabetes mellitus screening	Positive	90.3	77.9	71.2	0.003
Hepatitis B screening	Positive	92.5	75.9	70.5	0.001
HIV/AIDS screening	Positive	79.6	70.3	68.2	0.047
Immediate chairside screening	Positive	92.5	79.0	73.5	0.002
Lab sample screening	Positive	82.8	69.2	62.9	0.005
Height & weight measurements	Positive	84.9	75.4	69.7	0.031
Blood pressure measurements	Positive	92.5	79.0	73.5	0.002
Blood sample collection	Positive	93.5	72.8	67.4	0.001

Younger participants (20-35 years) show the highest willingness for medical screenings in dental settings compared to older age groups. Willingness for immediate chairside screening, diabetes screening, and blood sample collection is significantly higher among younger individuals ($p < 0.005$). Older participants (>50 years) display lower willingness across all screening categories, emphasizing the need for targeted awareness campaigns to increase acceptance among this group (Table 6).

Discussion

The findings of this study highlight significant demographic and socioeconomic disparities in health screening willingness among participants, particularly in relation to gender, education,

employment status, and economic standing. The results underscore critical gaps in healthcare accessibility and acceptance, aligning with previous research that has identified similar sociodemographic influences on health behaviors.

The study reveals a statistically significant gender difference in willingness for medical screenings, with male exhibiting a higher overall willingness compared to Females. These findings are consistent with previous studies that have demonstrated greater health-seeking sensitive behavior among women, often attributed to their increased health awareness and engagement with preventive healthcare and their demand of more services (15). However, men exhibited higher acceptance for specific screenings, such as cardiovascular disease and diabetes, which aligns with research by Smith et al. (2021) indicating that men are more likely to participate in disease-specific screenings when perceived personal risk is high (16, 17). A study found that women, particularly in lower-income settings, may have higher engagement in preventive healthcare due to their role in family health decision-making (18). However, the lower willingness of women to undergo HIV/AIDS and laboratory-based screenings in this study could be linked to stigma and privacy concerns, as noted in similar studies conducted in South Asian contexts (19).

In this study participants aged 20-35 years demonstrated the highest willingness for screenings, with willingness declining significantly among older participants (>50 years). The previous study showed the same pattern of willingness and described that the older population find procedures complicated and difficult to follow, which can reduce their likelihood of participating in screening (20). Furthermore, educational attainment played a crucial role in willingness for screening. Individuals with no formal education had the highest reluctance, whereas those with a master's degree exhibited the highest acceptance and a previous study showed the same pattern of willingness among highly educated population (21). These results corroborate the findings of a study conducted by Lillie-Blanton et al. (2008), which demonstrated a strong positive association between education level and health literacy, ultimately influencing proactive health behaviors (22). Similar studies in low-resource settings suggest that limited education often translates into misinformation about the benefits and risks of medical screenings (23).

Employment status was another significant determinant, with unemployed individuals demonstrating lower willingness for screenings compared to employed individuals. Economic instability has been widely recognized as a barrier to healthcare access, with studies indicating that financial concerns often lead to avoidance of preventive care due to the anticipated costs associated with follow-up treatments (24). Furthermore, our study's finding that individuals from extremely poor and chronically poor backgrounds exhibited lower willingness for health screenings aligns with broader literature emphasizing financial constraints as a primary obstacle to preventive healthcare uptake (25). Research in developing countries, in an

another study it was found that economic deprivation discourages proactive health-seeking behavior, reinforcing the need for subsidized screening programs targeted at economically disadvantaged populations (26).

This study was conducted in a single hospital setting, which may limit the generalizability of the findings. Due to constraints in budget and available resources, the study was unable to include multiple hospitals or population-based healthcare facilities representing diverse geographic, socioeconomic, and cultural contexts. Consequently, the results may not fully capture variations in health-screening behaviors across broader and more heterogeneous populations. Given the observed disparities, targeted interventions are needed to bridge the gap in screening acceptance. Educational campaigns aimed at enhancing health literacy among less-educated populations can improve understanding and reduce reluctance. Additionally, financial incentives, community-based health programs, and mobile screening units could mitigate economic and accessibility barriers, particularly for the extremely poor. Gender-sensitive approaches should also be considered to address specific concerns that may deter women from undergoing certain screenings, such as HIV/AIDS testing.

Conclusion

This study provided that willingness to undergo chairside screening for medical condition is strongly influenced by socioeconomic and demographic factors, including gender, age, economic status, education and employment. Educated, Younger, employed, and economically better-off participants showed significantly higher screening acceptance, while older and poorer individuals were more reluctant. Gender-based differences highlight both higher overall willingness among women and screening-specific preferences among men. These findings showed the need for targeted, equity-focused interventions to improve screening uptake among disadvantaged and high-risk populations.

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Ethical Approval:

This study was approved by the KMU-IPHSS Ethics Board of Khyber Medical University, Peshawar.

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Authors' Contribution:

PR: Conception, design and manuscript writing

NA, AMR, HS: Data collection and manuscript writing

SH: Data analysis and review

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