Refusal of potentially life-saving dental care: Antithetical conflict of ethical principles

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CASE PRESENTATION

Mrs Pea, a recently widowed 63 year old patient visited the dental hospital complaining of pain and swelling below the tongue. This pensioner has no immediate family except her 55 year old nephew, a nomadic truck driver living about 500 kms away. The attending dental specialist on the occasion of her visit was concerned that Mrs Pea looked unkempt, neglected and insecure. Clinical and radiographic examinations were undertaken, and she was diagnosed as suffering Ludwig's angina, originating from carious teeth 37and 38. The infection was bilateral but confined to the submandibular area. Mrs Pea was informed of the seriousness of the condition, and the need for immediate intervention was emphasised. The benefits and risks of the required treatment were discussed with her, yet she refused surgical intervention (including extractions) but requested alternative management instead. Throughout the consultation, Mrs Pea was attentive, interacted well with the specialist, sought clarification and demonstrated clear understanding of the intervention as suggested. Mental examination of the patient indicated that she was indeed fully competent. Anticipating that the condition could worsen, the specialist prescribed antibiotics and advised the patient to come back if and when her condition changed. She was then discharged, and all events of the day were recorded for future reference.

A few days later, Mrs Pea was wheeled into the Maxillo-facial Clinic; she had a running intravenous line which had been inserted at the referring hospital. Her condition had deteriorated; the infection had spread to other fascial spaces and she was struggling to breathe. The specialists on duty reiterated the advisability of the treatment modality previously recommended and informed her of the risks and benefits of treatment or refusal of care. Still Mrs Pea was adamant that she did not need the treatment as suggested. Her nephew, who was present, reported to the specialists that despite his relentless persuasion, her aunt was unlikely to accept treatment as she suffered from severe dental phobia and intense anxiety about dental treatment.

Confronted with this dilemma, the specialists requested an opinion from an ethicist on how to resolve this predicament. Ethical questions raised pertaining to this clinical predicament included the following: Whether Mrs Pea's decision to refuse potentially life-saving care was rational, given her emotional state? To what extent was dental phobia impacting on her ability to give valid informed consent? Could doctors impose paternalistic medical authority in view of her questionable mental state, and institute the prescribed dental treatment?

DISCUSSION

Patient with dental phobia – understating the moral context of autonomy

Central to this dilemma is the adversative conflict between three fundamental ethical obligations. Therefore, resolving this case requires reconciliation of these principles:

(i) beneficence or duty to promote the wellbeing of the patient,
(ii) non- maleficence or duty to protect the patient from harm and
(iii) autonomy or duty to respect the wishes and preferences of a competent patient.[1-4]

Historically, the decisions of doctors were not to be challenged, and the opinions of patients were largely disregarded. The doctors "know best" mentality entrenched this power asymmetry in decision-making in the medical profession. For a variety of reasons, medical paternalism remains established and perpetuated in clinical care.[5,6] Patients are still not accorded sufficient opportunity and space to influence the course of their treatment and care. Fortunately, the chasm that pervades patient-doctor relationship has been greatly reduced in the past few decades.[6] Increasingly, the

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autonomy of the patient is receiving considerable recognition in clinical practice, attributable in part to the teaching of bioethics and ethics in medical schools, and also to the rising risk and cost of litigation.[7]

According to the World Medical Association's Declaration on the Rights of Patients[7]: "the patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his or her decision. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapeutic." This means that competent patients could refuse treatment even if it could result in disability or death.

Decisions by patients to depart from beneficial medical recommendations challenges the professional values, ethos and the foundational rationale for medical care. The refusal of a patient to accept a suggested course of treatment fundamentally contradicts the obligation of the doctor to beneficence and non-maleficence and favours autonomy. In such instances doctors should be concerned about a patient's detrimental and "irrational" behaviour in the light of available and appropriate treatment. Doctors are thus obligated to investigate and identify the cause of "irrational" behaviour as a prerequisite to management of the patient.

The notion of irrationality presupposes that an objective assessment of decisional capacity has been undertaken, and that the patient was found to be inadequate in essential functional areas. A plethora of mental status assessments proceeding from simple to complex formulations have been developed to provide objective patient assessment.[8-10] Using these tools, all tenets of informed consent, viz. information, comprehension, voluntariness and decision making, including the ability to communicate choice, can be evaluated to determine the patient's mental state. There is consensus that medical conditions associated with increased risks of serious morbidity and mortality require stringent tests of competence, as associated decisions by patients and doctors could have grave consequences.[11] First, if competent patients are wrongly diagnosed, then doctors could paternalistically impose their preferred treatment without the valid consent of the patient. Secondly, if incompetent patients are erroneously diagnosed as competent, they may not receive the therapy, however appropriate, that they, in their incompetence, do not accept. This ethical obligation to respect an irrational decision could lead to unwarranted harm to the patient. When patients refuse treatment the doctors need to understand the basis of this decision. Since the burden of proof lies with the doctor, it is imperative that the determining cause and the appropriateness of refusal of care by the patient is thoroughly examined and appraised.[12]

The consensus is that stressful clinical circumstances may severely impair the ability of the patient to process the information provided.[11-13] Schwartz-Arad *et al*. found that patients with phobia demonstrated a superior understanding of information provided by doctors.[13] These patients are not naïve, but extremely sensitive to threatening information, hence their increased priority and attention to detail about their condition and their improved comprehension. This heightened attention to detail equally heightens the perception that clinical procedures are painful, and raises the levels of fear. Phobic patients display irrational perceptions of clinical events, which may "impair functioning of the mind" and may place the cognitive capacity in question.[14,15] Phobia may affect the manner in which the patient recalls, comprehends, views and believes that the risks and benefits of treatment apply to their own situations.[11,12] In extreme cases, patients may associate simple clinical procedures with fatal outcomes. For example, fearful patients may associate a basic treatment such as a dental extraction with permanent disability or even death. Such states of mind can be incapacitating and will not be conducive to free and valid consent.

Dental phobia necessarily diminish voluntariness, as it exposes patients to situations that reduces their possibilities to act freely and without coercion.[12,14] The characteristic avoidance of routine dental care in favour of urgent symptomatic treatment, denies these patients sufficient time to reflect on clinical information provided.[15,16] In emergency situations, patients are unable to reflect on their needs and cannot articulate their preferences in good time, thereby compromising autonomous decision making or validity of consent.

Evaluating Mrs Pea's situation

Blind respect of autonomy is problematic when a cognitively competent patient fails to utilize information provided to reach rational decisions. Patients experiencing emotional episodes, in the majority of cases, are unable to process information and to make sound decisions about their care.[17] Mrs Pea refused dental treatment and was set on going home. Her decision to reject treatment is attributed to extreme fear of dental care, leading to a self-perpetuating cycle of avoidance of dental care. Her dental history indicates procrastination and a lethargy in seeking dental treatment when clinical options are available. According to the attending specialists it is reasonable to conclude that Mrs Pea received adequate information, and understood the risks and benefits associated with the intervention. We further recognise that her psychological state might have heightened an appreciation of her medical situation and the proposed treatment. As a result of her amplified perception of clinical events, it is reasonable to conclude that Mrs Pea's ability to apply all available information to her situation was severely impacted by her phobia, hence her "irrational" stance and inability to recognise that refusal of treatment could end her life. Additionally, the urgent and serious nature of her condition did not present sufficient time to apply her mind to the situation in reaching a rational decision. Such circumstances are not conducive to free and voluntary consent. Structural barriers such as a lack of communication by the practitioner accompanied by an inadequacy in his/her affective abilities to manage Mrs Pea's situation further compromised the ability of the patient to provide valid consent. We can conclude that, given her state of mind, Mrs Pea was not able to give free and voluntary informed consent.

Managing patients with dental phobia: implications for dental professionals

Obtaining informed consent from patients with dental phobia is achievable but challenging, especially for inexperienced clinicians. It is prudent for doctors to refer patients for objective mental examination if decisions they take about their treatment are deemed "irrational". If the assessment outcomes indicate that the patient is indeed mentally incompetent, then legally appointed guardians should be involved in the implementation of proposed treatment. In cases where the patient is declared mentally competent

despite their perceived "irrational" decision making; the following practical measures are suggested:

Clinicians should investigate the underling determinants of irrational behaviour, as, for example, in this case, dental phobia is implicated. Factors like culture, socio-demographic and environment are reported as contributors to perceived irrational patient behaviour. Dental phobia can be exacerbated by unfavourable stimuli in the clinical surroundings. Therefore creative measures should be sought to convey necessary information to patients without triggering undesirable patient reactions. The use of well-structured leaflets have been proven effective in communicating information and increasing knowledge of patients.[18] In addition, undertaking patient consultation in secluded spaces, away from clinical areas, may assist in alleviating the intensity of phobia. Flexibility is necessary when seeking consent from irrational patients; doctors ought to acknowledge expressed fears and misconceptions, and find innovative ways to manage them. Good rapport and working relationship between patients and doctors can make or break the consent process.[19]

CONCLUSION

Dental phobia impacts negatively on valid informed consent, which is a legal and ethical requirement for clinical management of patients. Creative ways of dealing with anxiety should be explored to enable their patients to make informed decisions about their care, including refusal of treatment. Health systems could advantageously be re-engineered to minimise structural barriers to informed consent.

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