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

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 37 and 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

D Pagollang Motloba: BDS, MPH (Epid), MDent (Comm. Dent), MBLS
Head, Department of Community Dentistry, School of Oral Health Sciences, Sefako Makgatho Health Sciences University.
E-mail: Pagollang.motloba@smu.ac.za.
autonomy of the patient is receiving considerable recogni-
tion 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: “the patient has the right to self-
determination, to make free decisions regarding himself/ herself. The physician will inform the patient of the con-
sequences 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 rec-
ommendations 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 es-
cential functional areas. A plethora of mental status as-
sements proceeding from simple to complex formula-
tions have been developed to provide objective patient
assessment.9-10 Using these tools, all tenets of informed
consent, viz. information, comprehension, voluntariness
and decision making, including the ability to communi-
cate 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 asso-
ciated 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 errone-
ously diagnosed as competent, they may not receive the
therapy, however appropriate, that they, in their incompe-
tence, 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 deter-
miming 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 in-
formation provided.11-13 Schwartz-Arad et al. found that pa-
tients with phobia demonstrated a superior understanding
of information provided by doctors.13 These patients are
not naïve, but extremely sensitive to threatening informa-
tion, 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 percep-
tions of clinical events, which may “impair functioning of
the mind” and may place the cognitive capacity in ques-
tion.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 pa-
tients 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 con-
ductive to free and valid consent.

Dental phobia necessarily diminish voluntariness, as it ex-
poses patients to situations that reduces their possibilities
to act freely and without coercion.16,14 The characteristic
avoidance of routine dental care in favour of urgent symp-
tomatic 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 underlying 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. 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.

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.

References

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