Oral Medicine: Ethical Implications and Considerations

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INTRODUCTION

With the ever-increasing environmental exposures of the oral cavity to pathogens and potential carcinogens associated with habits (e.g. smoking, vaping, waterpipe, etc.) clinicians should remain vigilant in order to ensure the practice of ethical principles of care.[1]

Many Oral Health Care Workers (OHCW) – such as Dentists and Oral Hygienists – may experience uncertainty as to how to navigate the discussion when an oral presentation is noted that warrants further investigations. It is imperative that the OHCW remain objective, clear, concise and ensure dignity and truthfulness remain intact during these discussions with the patient. The predicament that may present is how can the OHCW motivate a patient for referral for special investigations (such as histopathological assessment), without offering the patient a diagnosis, instilling excessive fear or insufficient urgency to act.

CLINICAL CASE SCENARIOS

Patient A presents with a lesion on the palate that is small and flares up from time to time. The patient does not experience any pain.

Patient B presents with a white lesion in the cheek and has not noticed it until the examination by the dentist.

Patient C presents with a chronic lesion on the tongue. The patient presented with a history of receiving treatment several years ago for this same area from a non-dental specialist and with a diagnosis of a "benign lesion previously determined".

Patient D present with active oral lesions originating from a notifiable transmittable disease such as a sexually transmitted infection (STI) e.g. Syphilis.

DISCUSSION

The OHCW should never make a perceived diagnosis for any of the case scenarios above, in order to prevent a discussion with the patient or to avoid disclosure of the findings of the oral examination. The OHCW has an obligation to disclose all the findings of the oral examination to the patient. The patient has the right of autonomy on their treatment and it is important for the OHCW to involve the patient in decision making process[2]. The potential difficulty faced by the OHCW (in the roles of a General Dentist or Oral Hygienist) is that in most cases they are the first point of contact and examination. The OHCW needs to emphasize the importance to the patient for seeking specialist care for the relevant special investigations and subsequent treatment based on the histopathological diagnosis. This discussion regarding the importance for referral needs to be completed without leading the patient towards a diagnosis or creating a perception regarding the prognosis. There are patients that will give push-back to not pursue a consultation with a specialist. This is especially true for case scenario C – as previous investigations were performed, or due to an absence of symptoms associated with case scenarios A and B. The patient's autonomy to not seeking treatment has been reported to be influenced by a fear of the biopsy results (65% of cases)[3] and the anxiety of the patient regarding the biopsy with the specialist (23% of cases).[3] Due to these and other personal situations (such as financial constraints), the patient may hesitate to disclose, could result in the refusal to seek further treatment and will present the OHCW with ethical difficulties. OHCW have a natural pre-disposition towards the corner stone of ethics namely beneficence. This is to act in the best interest of the patient at all times.[2] The clinician is additionally faced with the non-maleficence of "doing no harm". [2] The inkling of the OHCW for case scenarios B and C of the possible serious differential diagnosis and realising the sequelae of non-treatment, should never prompt the clinician to overstep and offer a possible diagnosis to convince the patient to present for a referral. Definitive diagnosis and treatment option discussion may only occur after biopsy and histopathological investigations. Even in case scenario A, where there is no pain and palatal lesions are not regularly seen, the patient must be referred to ensure beneficence and non-maleficence is duly enforced.

Cases where patients present with a diagnosis, that may bear considerable health implications for an uninformed partner or spouse (such as case scenario D), may leave OHCW feeling conflicted as to their responsibilities to the exposed individual. There are many reasons why a patient may refuse disclosing their diagnosis to a third party. In a study[4] it was reported reasons for patients not disclosing a STI diagnosis as inadequate access to education, concern of stigma associated with diagnosis, fear of accusation of infidelity, threat of violence from the partner and the risk of dissolution of the relationship. The burden of responsibility for OHCW is limited to informing the patient of their STI diagnosis and the importance of disclosing this information and notifying their sexual partners.[4] This approach is potentially in conflict with other ethical considerations, such as the harm that may come to an uninformed partner. OHCW may also feel conflicted as they are unsure whether a partner notification will take place at all. An OHCW may only make a disclosure regarding a diagnosis without patient consent, when it involves disclosures

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in public interest that outweigh the patient's interest to confidentiality[5] for example in cases of human retroviral disease (HIV) exposure where serious harm or death are consequences of non-disclosure and failure to receive prophylactic treatment.

In most cases the OHCW-patient relationship is established and this ensures the patient is confident in maintenance of their dignity and the OHCW maintaining truthfulness (veracity). This "comfort" enhances the shared-decision-making discussion and will allow the patient to ask questions without prejudice and be involved in the referral process to a specialist, while stating the importance of the patient seeking the further care. When there is no patient-OHCW relationship present, this shared-decision-making discussion will be more challenging to the OHCW. It is the obligation of the OHCW to educate regarding referral, provide the patient with a referral letter and note in the patient records a referral was provided.[6]

When the shared-decision-making process breaks down and the patient remains adamant that they do not want to seek further treatment, the OHCW should make detailed notes on the discussion[7] and the copy of the referral letter that was not accepted should be noted in the patients file.[6] Ideally, take a metered photo record with a periodontal probe of the respective lesion, should the patient consent for record purposes. The OHCW may not proceed to discuss the scenario with their usual specialist referral pathway; as the patient has declined further treatment by exercising their autonomy.[5] The OHCW must retain the patients' rights to confidentiality and privacy until the patient chooses to pursue a consultation with the specialist with the provided referral letter. Upon subsequent dental visits the OHCW is required to continuously record the presentation of the lesion, and renew the consent for the photographic record. The OHCW must re-motivate, encourage and provide a newly dated referral letter towards the patient for visiting the specialist for biopsy and histopathological assessment.

Some patients would want to have clarity at the oral examination visit, if there is a chance for the lesion present to be malignant. From previous literature, it was reported as common practice for OHCW to estimate the patients' expectations, reaction and the way they would like to receive the diagnosis of a malignant nature[8] even before a histopathological diagnosis is confirmed. The OHCW should always maintain beneficence, however remain mindful that the clinical presentation of oral lesions is only one aspect of assessment and the diagnosis and severity (i.e. degree of dysplasia) can only be determined histopathologically. The clinician that decides to make the diagnosis, without histopathological assessment or proceeds to biopsy the lesion themselves, will be evaluated on the same level of standard of care as a specialist, should any law-suits and Ethical Regulatory Body inquiries transpire.[6] HPCSA guidance is set out in Ethical Rule 21, Performance of Professional Acts, stating that a practitioner shall only perform a procedure that is deemed to be out of scope, or the when the clinician is not adequately qualified or experienced, in the event of an emergency.[9] The discussion of a differential diagnosis by a non-treating OHCW that could lead to a perceived diagnosis discussion, must be managed carefully with respect and dignity towards the patient. Therefore, the non-treating OHCW, should try to maintain a neutral position, considering the patients' fear of a malignant diagnosis and re-assure them until the definitive histopathological diagnosis is confirmed by the specialist.

CONCLUSION

The OHCW remains the first patient contact and must decide how they would like to share information comprehensively to ensure a shared-decision making process, without necessarily misleading the patient to a possible diagnosis. The OHCW should remain cognisant that should the offered diagnosis be incorrect, the patient would have suffered an incorrect diagnosis and the patient could pursue various legal avenues to remedy their perceived trauma. The clinician that would like to consider the sensitive nature of the oral medicine referral process could utilise phrases and wording based on their clinical expertise and patient assessment of readiness to receive the information, such as:

"I have completed my oral examination and I have noticed something on the "area of the [insert location]". This is not the normal representation that would usually be present in this location. As your OHCW, I need to recognise that something looks different from the normal presentation and provide you with the appropriate referral letter. The specialist clinician, I will refer you to, is a specialist dealing with oral medicine and their consultation is essential to achieve a final diagnosis and treatment plan. Because, I am unable to provide you with direction towards the final diagnosis of the "area of the [insert location]" please do not feel that I am being dishonest or do not have your best interest at heart. It is important for me to let you know that a definitive diagnosis in most cases can only be made by a biopsy and subsequent histopathological assessment.

Because I am not a specialist and I am not adequately trained in treating oral medicine conditions / lesions, it could be perceived as out of scope if I were to offer you a diagnosis. Further should my diagnosis be incorrect upon histopathological assessment, you would have endured unnecessary emotional trauma with the diagnosis. I realise you might have some questions towards the seriousness of the "area of the [insert location]". I can confirm that based on the provided history of the "area of the [insert location]" it has a "history of recurrence / non-healing / never pained / tissue shows colour changes / tissue show texture changes / pain / ex" and I would recommend that it is investigated further by a specialist. I realise it might be frustrating that I am unable to give you a final diagnosis at this stage, but be assured we will do everything we can as a team to achieve the best possible treatment outcome, irrespective of what we might find in the biopsy results". It is important to remain calm about the situation and we will systematically manage the scenario as more information becomes available. May I contact the referring specialist and send them your information in the form of a referral letter or alternatively I will provide you now with a referral letter and you can contact the specialist on your own accord?"

DECLARATION

No conflict of interest declared.

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