

The Vulnerable Patient – An Ethical Dilemma

Description of the Case:

Mr. M is a 70-year-old man who presents to me for a prosthodontic evaluation during my third year as a dental student of the University of Washington School of Dentistry. Mr. M has a noticeable limp and explains that he is currently suffering from a sciatica and is waiting for it to pass on its own. As I begin gathering Mr. M's health history, I notice several inconsistencies in his reporting and note that Mr. M is slurring his words and lacks coherence in his speech. I suspect that he may be under the influence of alcohol and begin inquiring. Mr. M claims that alcohol helps with the pain from his sciatica. As I continue with our consultation, I explain that I cannot provide treatment to patients under the influence, but that I am willing to continue with the appointment if he understands that no treatment will be rendered today and remains calm and cooperative. At the end of the appointment, I inform Mr. M that he needs to come sober to his next appointment and that I will be going over all that was discussed today at his next appointment.

One week later, Mr. M returns to the dental clinics. While Mr. M appears sober, I notice that his limp has gotten worse. He admits that his sciatica has worsened, but still, Mr. M refuses to see a physician and re-affirms that his condition will heal on its own. He then tells me that his chief motive for coming to the school is to have four broken porcelain crowns on #6, 7, 10, and 11 replaced. He explains that he has not had regular dental care, that the last time he received any kind of dental treatment was two years ago and that everything had been done in the span of two full days. He said that soon after, the crowns began to chip catastrophically, exposing the underlying dentin, making him look like a "bum" to put it in his own terms, and cutting his tongue. Mr. M did not seek further dental treatment until his visit with me. Upon seeing the x-rays, I realize that Mr. M has had full-mouth rehabilitation and that only the mandibular anterior teeth are untouched. An evaluation by the supervising prosthodontist reveals that the crowns were made of a material that is no longer used in this capacity due to its poor clinical success and that the choice of material is likely to be the reason behind the many chips and fractures in Mr. M's crowns.

I proceed with a periodontal evaluation of Mr. M's mouth and realize that Mr. M suffers from periodontitis with deep pockets and subgingival calculus in all four quadrants. He mentions that while his last dental exam was two years ago, he's never been informed of having gum disease. I tell Mr. M that while I cannot attest to what his previous dentist has told or recommended to him, it is my duty to provide him a summary of my findings and evaluation of his oral status. He tells me that periodontal treatment is not his priority, refuses my recommendation for periodontal treatment, and insists on only wanting the crowns replaced.

Finally, Mr. M also complains that his mandibular partial has been rocking ever since its delivery two years ago with the same dentist and that it has created some significant sore spots and "messed up" his bite. I inform him that school policy prohibits me from adjusting appliances that were not originally delivered at the school and that I would need to make him a new one later on down the road. Mr. M is infuriated and claims that he will take care of the partial himself at home with a set of pliers if I just deliver his crowns.

Summary of the Ethical Issues at Hand:

This case, which I encountered towards the end of my third year at UW, presents a plethora of ethical issues, including:

1. Issues related to treating patients under the influence, including obtaining consent.
2. Issues related to self-neglect regarding untreated conditions such as the patient's sciatica.
3. Issues related to the quality of the services rendered by Mr. M's previous dentist.
4. Issues related to the patient's seemingly faulty decision-making, including his refusal to treat periodontitis or sciatica.
5. Issues related to consequences which may result from the school's policy of prohibiting its student dentists from adjusting appliances fabricated elsewhere.

Relevant Washington State Laws:

RCW 74.34.020(19) provides definitions for the terms "vulnerable adult" and "self-neglect." According to this law, a vulnerable adult may be anyone who is 60-years of age or older, "has the functional, mental, or physical inability to care for himself or herself," and who "self-directs his or her own care [...]." Furthermore, under this law, "self-neglect" is defined as a "failure for a vulnerable adult, not living in a facility, to provide for him/herself the [...] services necessary for the vulnerable adult's physical or mental health." It can clearly be argued that Mr. M may be deemed a vulnerable adult who takes part in self-neglect. Another section (RCW 74.34.035) of the same chapter of the law mandates that any reasonable sign or cause to believe that neglect or exploitation of a vulnerable adult has occurred be reported immediately. It is therefore not unreasonable to contemplate reporting Mr. M's previous dentist given the expert findings of the UW's prosthodontist.

RCW 11.88.010(a)(e) defines the laws relating to patients who may be considered incompetent. According to the law, a person may be deemed incompetent "by reason of [...] habitual drunkenness or [...] caring for himself or herself." Mr M's decision to present under the influence of alcohol to his first appointment can be argued to be a display of self-neglect and incompetence. However, the key element rests in the Mr. M's declaration that he uses alcohol to reduce the pain induced by his sciatica, a condition for which he refuses to obtain a professional evaluation. While the law prohibits "age, eccentricity, poverty, or medical diagnosis alone" from being sufficient to justify a finding of incapacity, the patient's overall attitude towards self-care, his lack of understanding of the implications of his treatment decisions and oral health needs, as well as his age and usage of alcohol for therapeutic purposes do point towards a possible application of this law.

Should the patient be determined to be incompetent, there are rules and regulations governing who may be authorized to provide consent. These persons are defined in RCW 7.70.065. It would therefore be the treating dentists' responsibility to determine whether Mr. M is capable of providing fully informed consent, even at appointments where he is sober, and to further determine who may be able provide consent for treatment.

RCW 18.130.080 and RCW 18.130.180 describe the implications of dentists who may have displayed incompetence, negligence, or malpractice thereby resulting in injury to a patient and creating an unreasonable risk. Since Mr. M's previous dentist is liable for the quality of the treatments rendered, I would be under the obligation to further inquire about the circumstances surrounding Mr. M's treatment

two years ago, as well as report the grievances to a regulatory body, either a Peer Review Committee or the Dental Quality Assurance Committee (DQAC) depending on the previous dentist's affiliation status with a local dental society.

ADA Code of Ethics: Patient Autonomy

Section 1A of this principle dictates that the patient should be involved in the treatment decisions, which in turn must be presented in such a manner that the patient understands them and their implications. While Mr. M is stubbornly decided on what he does and does not want, his judgement and ability to care for himself seems clouded. Mr. M refuses to abide by my professional recommendations, which I believe to be in the patient's best interest, and continually displays cherry-picking behavior by electing to proceed only with the treatment recommendations which align with his own desires. I firmly believe that treating nothing but the defective crowns will result in failure of the dentition in subsequent years as a result of Mr. M's uncontrolled periodontal disease, and will ultimately cause more harm than good.

Furthermore, Mr. M's habit of refusing professional advice seems to be a central issue with regards to his care. For example, he continues to suffer from his sciatica, but appears to treat it with a remedy which may harm him further. These decisions, along with his intoxicated demeanor at our first appointment, are indications that Mr. M may not be in a position to assume self-governance and that a person should instead be appointed to aid Mr. M in his overall care. This move would be in agreement with the laws on vulnerable adults and may help Mr. M receive the care he ultimately needs.

On another note, Mr. M could be advised to obtain a copy of his records from his previous dentist, as detailed in Section 1B. Doing so would help elucidate the circumstances surrounding the manner in which treatment was delivered two years ago, including possible findings of periodontitis with no associated diagnosis, reasons behind the choice of type of porcelain, and any subjective findings the previous dentist may have noted on Mr. M's demeanor.

ADA Code of Ethics: Nonmaleficence

Under this principle, my main duty is to provide Mr. M treatment that will only benefit and not harm him. This principle comes to play in several aspects of the case. First of all, it is reasonable to question whether Mr. M's previous dentist exercised his duty to uphold the principle of nonmaleficence. The dentist's rendering of treatment in what could possibly have been an already periodontally-compromised dentition is contrary to current knowledge and thus represents a violation of nonmaleficence. The dentist should have consulted a specialist, namely a periodontist, as mandated by section 2B of the code of ethics if he was unclear as to how to proceed with regards to the patient's periodontal condition. In addition, the dentist' use of outdated techniques for crown fabrication only contributed to Mr. M's current concerns and have harmed him in unacceptable ways. Whether the dentist lacked the necessary education on those topics or simply displayed blatant negligence remains to be proven. However, in either case, the dentist would be in violation of the principle of nonmaleficence.

Since Mr. M has consulted me with regards to his dental treatment, it is my duty to also protect the patient from harm. This not only applies to my own decision-making, but also includes self-harm. As such, it is my obligation to refuse to treat Mr. M should he display signs of intoxication. I must also refuse to deliver Mr. M's new crowns until his periodontal condition is addressed through periodontal treatment.

In addition, it is my duty to prevent Mr. M from potentially harming himself through neglect or self-medication. I should therefore address the patient's neglect and dangerous self-treatment habits of his sciatica, either by urging Mr. M to involve a relative or person in his care or by contacting a government agency to evaluate Mr. M as a potentially vulnerable adult.

Since the patient is also experiencing pain as a result of his sharp crowns, it wouldn't be unreasonable to smooth the sharp edges, relieve the patient of pain, and continue the discussion on whether or not to proceed with treatment and under what circumstances. This would abide by this principle of not doing harm, by preventing future harm from occurring.

Finally, at what point does the school's policy of not tinkering with appliances made by outside dentists begin to violate the principle of nonmaleficence, especially if the appliance is causing the patient harm ("my bite is all messed up")? Having identified the over-contoured points on Mr. M's mandibular prosthesis, I knew what needed to be done to make the appliance tolerable for Mr. M. However, the schools' policy (established for liability reasons) prevented me from doing so, thereby indirectly encouraging Mr. M to resort to homemade fixes.

ADA Code of Ethics: Beneficence

Under this principle, the dentist has a duty to act for the benefit of others, "primarily for that of the patient and the public at large." The principle, however, goes on to state that "most important is the competent and timely delivery of dental care within the bounds of clinical circumstances presented by the patient, with due consideration being given to the needs, desires, and values of the patient." It is difficult to inquire on the ways in which this principle may not have been upheld by the previous dentist, given the lack of data on the circumstances surrounding Mr. M's case, aside from his own testimony and rendition of events. However, it has many applicable aspects with regards to my approach to Mr. M's treatment. For one, my duty lies in ensuring that whichever treatment option I will agree to with Mr. M is an option consistent with the standard of care. Section 3E also requires that any signs of abuse and neglect be reported to the proper authorities. In this case, it should be investigated as to whether Mr. M's previous dentist may have taken advantage of Mr. M by providing him with only the treatments he may have asked for and ignoring other vital aspects of his condition, including his periodontal disease, provided it was present at the time. As the patient's dentist, I am also now under the obligation of noting and reporting any signs of neglect, including self-neglect, on behalf of Mr. M if I determine that he be considered a vulnerable adult. His inappropriate use of alcohol, refusal to seek treatment for a disabling condition (sciatica), refusal to comply with treatment recommendations, and tendency for self-medication (adjusting his own partial), in addition to his elderly age, are all indicators of self-neglect and make a strong case for further action, consistent with the principle of beneficence and the law.

ADA Code of Ethics: Justice

I believe that my decision to continue conversing with Mr. M, yet refusing to render treatment, despite his apparent impaired state was consistent with the principle of justice which states that the "dentist's primary obligation include dealing with people justly and delivering dental care without prejudice." Because Mr. M was compliant with my line of questioning and did not display any sign of aggressive or uncooperative behavior during that first visit, I determined that it would only be fair for me to see Mr. M and instruct him to return in a more coherent state-of-mind. During that first appointment, I was able to get a sense of Mr. M and his situation which aided my judgment and treatment decisions in the

subsequent appointment. On the other hand, I could very well have applied Section 4A of the code which empowers dentists to exercise reasonable discretion in selecting patients. It could be argued that refusing to accept Mr. M as a patient simply based on his level of intoxication during his first appointment is warranted and appropriate.

Section 4C of the code is especially relevant to this case. Under this section, a dentist is “obliged to report to the appropriate reviewing agency [...] instances of gross or continual faulty treatment by other dentists.” It is clear that the treatment rendered, at least with regards to the material used for the crowns was substandard. While it is my responsibility to inform Mr. M of the state of his oral health, my comments with regards to his previous dentist must not unjustly imply mistreatment.

ADA Code of Ethics: Veracity

Under this principle, the “dentist has a responsibility to be honest and trustworthy and respect the position of trust in the dentist-patient relationship.” I believe that my attitude towards Mr. M has been nothing short of truthful and representative of the ADA’s code of ethics. The previous dentist’s judgment however, could be called into question, after an inquiry as to the circumstances surrounding his treatment decisions is completed.

Conflicts between laws and ethical principles or between individual ethical principles:

As I reflected on the case at hand, one conflict stood out above all others between two of the code of ethics’ principles: Beneficence and patient autonomy. While the dentist has the obligation to report abuse and neglect under the principle of beneficence, s/he must also respect the patients’ right to self-determination and confidentiality. It is clear to me that Mr. M came to me knowing what he wanted. However, his impaired ability to make treatment decisions which are safe and reflect the standard of care undermines his autonomy. So while the patient has a right to autonomy, the dentist’s obligation to do good in the face of harmful behavior and caustic tendencies directly conflicts the patients’ rights to self-determination. In fact, the same can be said with regards to the laws regarding vulnerable adults whose ability to provide consent is taken away, and with it, their ethical right to autonomy. A resolution to this conflict lies mainly in the dentist’s judgment of the circumstances, weighing in the benefits and disadvantages for all decisions.

Another conflict which I see in this case is the disconnect between the principles of nonmaleficence and beneficence, and the school’s policy with regards to adjustments needed for the patient’s mandibular partial. While the school’s policies are clearly established for liability purposes, they neither allow the dentist to do good (beneficence) by “providing competent dental care” nor permit him/her to prevent harmful circumstances from occurring (nonmaleficence), since the patient explicitly stated that he will be taking a pair of pliers to his appliance.

Proposals for Resolution: How to proceed?

- With regards to addressing issues related to Mr. M’s previous dentist, one could either:

1. Contact Mr. M’s former dentist and inquire about the circumstances which may have led to the treatment decisions.
2. Suggest that Mr. M contact his previous dentist and request his patient records.

3. Contact the dentist to inquire on the circumstances and submit the case to the Dental Quality Assurance Committee if that doctor is not a member of a local dental society or to a peer review board if the dentist is a member of a local dental society.

I believe that the third option is most appropriate in this case. While the dentist may be given the benefit of the doubt with regards to his approach of Mr. M's periodontal disease since the extent of the disease at the time of treatment remains unknown, it is difficult to ignore the egregious errors committed in choosing substandard and clinically unacceptable material in the delivery of fixed and removable appliances.

-With regards to addressing Mr. M's state of impairment at his first appointment, one could either:

1. Turn the patient away and abandon the evaluation before the patient becomes a patient of record, thereby exercising the principles outlined in section 4A of the code with regards to patient selection in a lawful manner. A recommendation should be made to present sober at subsequent appointments.
2. Question the patient and make a judgment call on his state-of-mind after an evaluation of his ability to understand, of the threat he may pose to others in the office, and of his cooperativeness. Proceed with an evaluation but do not render treatment that does or does not require consent.

I believe the second option to be most appropriate. Since Mr. M was calm and cooperative during his first appointment despite being intoxicated, it only seemed just to provide the patient with respect and calmly inform him that no treatment will be rendered on this day and that the appointment will need to be rescheduled to another time. This is the option I elected for. Mr. M returned a week later, sober.

-With regards to the issues of vulnerability, self-neglect, and consent, one could either:

1. Continue to work with Mr. M until a mutually agreed-upon treatment plan is enacted.
2. Ask Mr. M to return to the office at a later date with a relative or loved one to aid in communicating the extent of Mr. M's condition and change his habits of self-neglect and harmful tendencies.
3. Report Mr. M to a government agency to have his situation evaluated and his ability to consent clarified.

I believe that the 2nd and 3rd options are equally appropriate depending on the circumstances. Being a believer in taking incrementally aggressive measures, I first asked Mr. M to return to see me at a later date with someone he trusts helping make decisions about his care. Only if that option did not suffice in helping Mr. M resolve not only his dental problems but also his sciatica and alcohol use, would I progress to option 3 to have Mr. M evaluated to be considered a vulnerable adult unable to consent for himself.

-With regards to issues related the consequences which may result from the school's policy of prohibiting its student dentists from adjusting appliances fabricated else-where, one could:

1. Do nothing and abide by the school's policy, allowing Mr. M to adjust his partial at his own risk.
2. Have Mr. M sign a waiver indicating that the school will not be liable for any deleterious modifications made to his partial.

3. Inform Mr. M that he should stop wearing the partial altogether and that a new one should be made by the School of Dentistry.
3. Modify the partial under the supervision of a prosthodontic faculty member and hope that the patient is satisfied with the changes!

This issue was difficult to address. If I had modified the partial, Mr. M would immediately have become a patient of record and the school would become responsible for the outcomes of Mr. M's future dental treatment. If nothing is done, however, the patient is at risk of causing more harm to himself. After consulting with many faculty members on the matter, I was told to wait until the issues of consent and patient autonomy are resolved to work on the partial. As such, I recommended that Mr. M not use his partial nor make any changes to his partial for the time being and subsequently return with a relative, at which time we could make a decision on how to proceed. Unfortunately, Mr. M never returned to the school after my second appointment with him and we were unable to get in touch with him.