BARRIERS TO AUTONOMOUS DECISION MAKING

Ozar-Hasegawa Ethics Essay Submission

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The United States Census Bureau reported that from 2010-2020 the Hispanic/Latino population grew from 50.5 million (16.3% of the U.S. population) to 62.1 million (18.7%). That is to say that in a 10-year time frame this community grew by 23%, contributing to more than half (51.1%) of the total U.S. population growth during this time (U.S. Census Bureau, 2022). Spanish-speaking Hispanics have been reported to have the highest risk of irregular dentist visits, least number of teeth, and poorest oral health compared to non-Hispanic whites, non-Hispanic Blacks, and English-speaking Hispanics (Han, 2019). The purpose of this narrative ethical analysis is to bring light to barriers of care and lack of autonomous decision making in the dental profession among the Hispanic community.

Roman shuffled into the clinic, bright-eyed, searching for the dental unit where his appointment would begin. As the dental student provider gestured toward the dental chair, he eased his way onto the seat and placed his hands clasped over his lap. The appointment began with the collection of the patient's medical and dental history. The dental student attempted to record the information she could, and then frantically tried calling the translation service as Roman spoke little to no English. I watched from the adjacent dental operatory as this interaction transpired. As I finished my assisting appointment, I approached the student and offered to translate. The dental student was thrilled that the existing language barrier could be eliminated and asked me to accompany them to acquire a panoramic radiograph. Roman's aged but bright yellow-green eyes appeared as downward crescent moons, wrinkled at the edges, which I could only imagine meant that under his mask was a kind smile. He sighed in relief that he could speak to someone that understood his language. At the ripe age of 80, he had just moved from Bogota a few months before to be with his family and receive treatment for infective endocarditis. He excitedly shuffled his way towards the panoramic machine, as we spoke more about his life, children, and grandchildren. As we approached the panoramic machine, he removed his mask and gifted me with the largest smile I had ever seen. He was completely edentulous, and shyly admitted his embarrassment about having no teeth but added that his children said it made him look "tierno", tenderly sweet.

Though I was happy to aid this patient, I could not help but think of the ethical issue presented before me: if there is a clear language barrier, can one truly receive informed consent? The dilemma is whether or not to proceed with clinical care when there is uncertainty about how much a patient understood. The main ethical principle that underscores this situation is patient autonomy. How can a patient truly make an informed decision about their health, if they do not fully comprehend what the treatment plan dictates? It is our duty as dental providers to offer all feasible treatment options and make a comprehensive treatment plan that best suits our patients' needs. We must respect patient autonomy when it comes to treatment choices. For this to be possible, a patient must understand the risks and benefits of the options presented, and an interactive model should be employed to maintain good patient-doctor communication. However, what is to be done when a patient arrives to the clinic, motivated to receive treatment, but does not speak the dominant local language? Additionally, it is well documented that dental health literacy can serve as a significant obstacle when striving to attain informed consent regarding dental procedures. A language barrier between the patient and provider can dramatically compound this professional quandary. This is not only an ethical dilemma but also a

cultural one. Research has shown that Latino patients often follow a paternalistic model when pursuing dental care and rely solely on the dentist to make decisions about their oral health. While a patient may be culturally accustomed to entrusting the dentist entirely with their oral care, it does not mean that providers should not advocate for patients to utilize their autonomy when selecting treatment options. Are we as providers taking the path of least resistance because it is more convenient than taking the time to reach true informed consent? It has already been documented that minority populations often receive less health information in order to make a treatment decision (Murray, 2007). Provider assumptions regarding low health literacy in patients can lead to the use of lay terms to such an extent that some important concepts are omitted entirely. Additionally, we may also enact biases that include stereotypes and unfair assumptions about our patients. With these potential pitfalls, how can we expect our patients to make the best treatment decision when we are not providing all the information needed? Many times, patients reluctantly or fearfully walk into the clinic or miss their appointment entirely due to existing systemic healthcare barriers that we, as hard-working student providers, often forget. Our own "oral medicine dialect" differs greatly from the normal English vernacular but adding the complexity of an entirely different language makes the margin of error far too great.

As I further pondered this dilemma, I discerned significant connections to Ozar's Central Values of Dental Practice, especially the first three: patient's life and general health, patient's oral health, and patient autonomy (Ozar, 2018). Dentistry is often considered as a very technical profession; nonetheless, without proper diagnosis, patient adherence, and doctor-patient communication we would be unable to achieve successful treatment outcomes. Possessing good hand-skills is only one aspect of dentistry. It is often thought to be the most important, however, this may not be the case. A patient's life and general health greatly depends on how we as dentists are able to communicate with them. It is essential to listen and record our patient's chief complaint and seek to address that issue so that their quality of life might improve. This also helps to establish trust between patient and doctor, which can improve health outcomes (Pearson, 2000). Often the source of poor quality of life stems from suboptimal oral health due to a lack of access to care, fear, or deficient oral health literacy. However, these issues in the presence of a language barrier make it difficult to discern a patient's chief complaint or identify the most prudent treatment options for that patient. All these areas connect back to patient autonomy, or the lack thereof, when a language barrier exists.

When reflecting on this ethical dilemma, the possible alternatives to address this issue should be considered. One possible option would be to do nothing. Continue to have students provide treatment to patients even when a language barrier is present and hope that some information is understood. This option is not ideal, as it could do more harm than good. By selecting this option, we would, in a sense, be ignoring or even denying the patient the opportunity to have any autonomy over their treatment. However, this approach may need to be employed in circumstances such as extreme dental emergencies or perhaps when planning to perform low-risk treatments. Though, this brings up the question of how do you accurately determine levels of risk? In truth, the level of risk associated with a procedure might vary from one patient to the next even for the same procedure. Therefore, I believe it is not appropriate to proceed without attempting to obtain valid informed consent.

Another option to address this dilemma could be more comprehensive patient assignments to dental student providers; meaning student language competencies should be taken and passed to avoid situations where the patient and provider are unable to communicate efficiently. Although the translation lines are available to students, they make appointments longer and inconvenient. Language barriers should also be noted on the patient health record so that student providers are aware before initiating treatment. Perhaps another alternative could be the utilization of pre-recorded informative videos on possible treatment options. In my experience assisting, student providers are oftentimes oblivious of potential language barriers that may exist for patients presenting to the school for dental care. There have been numerous times when I contacted patients via telephone to remind them of their appointments and was told that they couldn't come in but didn't know how to call and reschedule because of the language barrier. I have also had patients in the chair sigh with relief because they had no idea what their treatment options were to resolve their dental issue, until it was explained in their language. We are not only lacking in informed consent but also losing the trust of our patients. Building a foundation of trust and respect is a core pillar of our profession and these barriers to informed consent and access to care are negatively impacting our patients. However, this option is not without shortcomings. There are only so many students that can speak other languages fluently, and this therefore would limit the number of patients who could be seen with a provider that could communicate with them without assistance. Attempting to institute such an approach could unintentionally create another barrier of access to care.

The ultimate solution to resolve this issue is likely multifactorial and would require the modification of existing structures, processes, and potentially personnel within a dental clinic. But I wholeheartedly believe that we can and must do better regarding our interaction and communication with patients. I am optimistic that we can achieve success in this area of practice, as I have already experienced great improvements and feedback from patients with whom I have broken the language barrier. Roman completely entrusted me with his care and believed in my ability to translate the correct information. He watched patiently, with hopeful eyes, as the dental provider explained what the rest of his appointment would entail and the reasoning behind it, only picking-up a few words here and there. I translated the information and after that, my services were no longer needed, so I said my goodbyes and departed. The student provider rushed out behind me and asked if I wanted to take him on as a patient, because she was graduating soon. I remorsefully replied that I could not, as I would not begin to receive patients until I entered the third year of my program. Following our conversation, I could see Roman sitting in the dental chair looking back at me with his sweet, toothless smile. As I offered one final wave goodbye, I felt both pride and immense satisfaction that I was able to help eliminate barriers to care for Roman and ensure that he received the information, support, and clinical care that he and all our patients deserve. Nonetheless, accompanied with this sense of fulfillment, there lingered a bittersweetness knowledge that Roman was one of many, but I made all the difference to him. And that is all we can strive for as dental providers, to make our patients seen, cared for, and most importantly heard in a language they can understand.

Disclosure: This essay is based on true events and for that reason names have been modified to preserve confidentiality.

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