



AMA Journal of Ethics®

January 2022, Volume 24, Number 1: E6-12

CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

Should Dentists Treat Despite Medical Contraindications?

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Abstract

Dental treatment is contraindicated by some health conditions. As patients live longer and dentists treat more patients with underlying disease, patients often need general medical care before dental care can proceed. For US patients without access to health care and their dentists, lack of medical-dental integration can generate inequity, poor outcomes, and ethical questions. Individual dentists should advocate for patients who need general health care prior to dental care, but the professions of dentistry and medicine must also respond to macro-level health system gaps and failures.

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Case

Dr V is a general dentist completing a series of restorative procedures for Mr S. Today, during a visit for some fillings, a dental assistant, DA, informs Dr V that Mr S's blood pressure is 182/98 mm Hg. DA informs Mr S that his blood pressure is too elevated for elective treatment, so Mr S's appointment will have to be rescheduled. DA also notes that Mr S's blood pressure has been recorded as greater than 140/90 mm Hg for the past 3 visits, suggesting hypertension. Dr V encourages Mr S to visit his primary care physician for diagnosis and intervention. Mr S begs, "My teeth hurt. Please do the fillings. And I don't even have a physician."

Commentary

When a health care practitioner enters into a professional relationship with a patient, she enters into a therapeutic alliance with that patient. The therapeutic alliance describes the partnership through which the health care professional and patient effect beneficial change in the patient's health. The rationale underlying the therapeutic alliance is that it strengthens the personal bond between the treating clinician and the patient. Although it has been most extensively studied in the context of mental health,^{1,2} it is important in dentistry, too, as the patient and dentist typically have a long-term relationship.³ By going beyond the minimum ethical duty owed to a patient by establishing a therapeutic alliance, a clinician can enhance the patient-clinician bond and effectuate a better outcome for her patient in all aspects of that patient's health care.³

Dr V, like all health care professionals, is formally bound by the code of ethics of her profession. Although a number of organizations in dentistry, including the American College of Dentists,⁴ have a code of ethics, the code most widely used in the United States is the Principles of Ethics and Code of Professional Conduct of the American Dental Association (ADA).⁵ Even if she is not a member of the ADA, Dr V is bound by the ADA Code, as it is de facto the standard of ethical care for the dental professional. Additionally, many dental boards incorporate the ADA Code into their regulations, either explicitly or implicitly, making it the de jure code of ethics. For example, in its instructions on how to prepare for its dental ethics and jurisprudence exam, the Massachusetts Board of Registration in Dentistry lists as one of the resources the “Principles of Ethics and Code of Professional Conduct, American Dental Association.”⁶ Some state codes are more explicit in their incorporation of the ADA Code. The California Code, for example, states: “California Dental Association (CDA) members agree to abide by the tenets embodied in the American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct (ADA Code) and the CDA Code of Ethics.”⁷ Similarly, the Washington State Dental Association declares “The professional conduct of Association members is governed by the American Dental Association Principles of Ethics, the dentistry Code of Ethics, and applicable federal or state criminal statutes.”⁸ Several other states besides these two subscribe to the ADA Code,^{9,10,11,12} to which we now turn to assess Dr V’s ethical responsibility to Mr S.

ADA Code of Ethics

The ADA Code subscribes to the 4-principles approach to medical ethics—respect for patient autonomy, nonmaleficence, beneficence, and justice—popularized by Beauchamp and Childress¹³ and added a fifth: veracity.¹⁴ As is commonly the case when applying the 4 principles approach, Dr V finds herself caught between 2 seemingly irreconcilable principles—respect for patient autonomy and nonmaleficence. The degree of deference that patient autonomy ought to be accorded is a well-known point of contention. Some authorities are of the opinion that there are no limits to patient autonomy as long as there is no risk of harming others.¹⁵ Other commentators, however, express the view that a patient’s autonomy may be restricted if there is a threat of severe harm to a patient’s well-being or for other reasons, including, but not limited to, futility.^{16,17,18,19} If Dr V subscribes to the view that there are no limits to patient autonomy as long as there is no risk of harming others, then she has resolved her dilemma and is free to go ahead and treat Mr S. However, that point of view seems untenable to me. It is difficult to believe that there is no procedure or treatment that a physician or dentist would refuse to undertake no matter the patient’s protestations that he wants it and **agrees to the treatment**. An example of such a circumstance is when patients request the extraction of one or more teeth and especially when they request extraction of all their teeth for no sound dental or medical reason.²⁰ However, the most compelling argument that respect for autonomy is not without limit is to be found in the 4-principles approach itself, which is, after all, the 4-principles approach. If respect for autonomy always prevails, there would be no need for the other 3 principles. Moreover, if respect for autonomy is limitless, the relationship between patient and clinician would be determined purely by the marketplace and would render standard of care, among other things, a nullity. That the standard of care should not be deviated from is supported by the ADA Code, which states: “professionals have a duty to treat the patient according to the patient’s desires, *within the bounds of accepted treatment*” (emphasis added).²¹ The ADA Code’s admonition that treatment is to be rendered “within the bounds of accepted treatment” is in place partly in order to uphold the principles of nonmaleficence and beneficence. Thus, based on the ADA Code, which incorporates the

4 principles, and on the ADA's standard of care, which requires that elective dental care be delayed if the patient's blood pressure is greater 160/100 mm Hg and that even emergency dental treatment be delayed if a patient's systolic blood pressure is greater than 180 mm Hg and/or a patient's diastolic pressure is greater than 109 mm Hg,²² Dr V cannot ethically treat Mr S at today's session simply because he is insisting on it.

Next Steps

The next question facing Dr V is whether she has any obligation to Mr S beyond not treating him today. Based on the standard of care and also on the ADA Code's principle of veracity, which requires that dentists "be honest and trustworthy in their dealings with people,"²¹ she clearly has an obligation to inform him why she cannot treat him and to advise him that he should seek medical care to lower his blood pressure. The principle of veracity serves a number of purposes. It clearly requires a dentist not to lie outright, but it has a more nuanced application. Veracity also applies to the manner in which the information is presented to the patient; namely, it should be presented in an unbiased manner and not in accordance with the dentist's belief that a certain treatment is or is not indicated, which serves to bias the patient's decision in a certain direction.¹⁴

Having explained to Mr S why treatment cannot proceed, Dr V must decide whether she has an **ethical obligation** to help Mr S find a primary care physician. Nowhere does the ADA Code directly aver that a dentist has an ethical obligation to assist a patient in finding medical care. However, in the preamble, the Code states: "each dentist should share in providing advocacy to and care of the underserved."²¹ Since he lacks a primary care physician, Mr S can reasonably be construed to fall within the category of the underserved, and Dr V is therefore ethically obligated to advocate for his medical care. Furthermore, in Section 2, the Code holds that "professionals have a duty to protect the patient from harm. Under this principle, the dentist's primary obligations include keeping knowledge and skills current, knowing one's own limitations and when to refer to a specialist *or other professional*, and knowing when and under what circumstances delegation of patient care to auxiliaries is appropriate" (emphasis added).²¹ The words "or other professional," especially when read in conjunction with those in the preamble, can reasonably be interpreted to include nondental clinicians. This interpretation is supported by the ADA's General Guidelines for Referring Dental Patients, where it is stated that possible referral situations include "medical complications,"²³ as well as by the ADA's Advisory Opinion 4.A.1 concerning medically compromised patients, which states: "The dentist should also determine, after consultation with the patient's physician, if appropriate, if the patient's health status would be significantly compromised by the provision of dental treatment."²⁴

The principle of justice, embraced by the ADA Code, requires that "health services be accessible to individuals according to need" and accounting for resource availability.²⁵ Mr S certainly has a need, and the resource—access to a primary care physician or nurse practitioner—is not so limited as to render access to it impossible. He might simply need help accessing appropriate care. Virtue ethics and the principle of justice suggest that health care professionals must advocate for patients and promote equity²⁶; Dr V has a duty to assist Mr S in finding medical care.

Barriers

Although Dr V has as an ethical duty to assist Mr S in obtaining medical care that is no different than she would have if he required specialty dental care, a dentist attempting to refer a patient to a physician faces a number of barriers. As will become evident, her

attempt as an individual to aid Mr S in finding medical care runs into the dental profession's long-standing **position on public insurance** that stymies and often completely thwarts such attempts. Dentistry successfully opposed the inclusion of dental coverage under Medicare.^{27,28} While organized dentistry has been careful as to how it couched and continues to couch its opposition to the inclusion of dentistry under Medicare, the real reason underlying its opposition is the profession's concern that reimbursement rates would not be sufficient and would result in reducing dentists' level of income.²⁸ Even today, the ADA's position on the inclusion of dental benefits in Medicare is noncommittal at best and arguably opposed to it. As recently as 2018, the *ADA News* reported: "The ADA contributed data to the white paper [on adding a dental benefit to Medicare], but the Association's input," according to ADA President Joseph P. Crowley, "does not constitute endorsement of inclusion of a dental benefit under Medicare at this time."²⁹ As a result, with rare exceptions, dentists **do not work in the same practice** or even the same setting as physicians, and physicians are not in the habit of receiving referrals from dentists. Furthermore, neither ethics nor the law requires a physician to accept a new patient. The difficulty facing Dr V is not one of her making, but rather one that is the result of a systemic shortcoming. She cannot reasonably be expected to singlehandedly change the "system." Referring Mr S to an emergency room is an unreasonable use of that resource. If Dr V knows (of) a physician who is accepting new patients, she can refer him there. Referral to a community health clinic would very likely result in success. Additionally, options other than physicians exist. Nurse practitioners and physician assistants are 2 such groups. If Dr V has assiduously attempted to refer Mr S to any of the above, then she has fulfilled her ethical duty.

Conclusion

The situation in which Dr V finds herself—namely, attending a patient who requires medical care before dental treatment can proceed—is not unusual. For patients who have ready access to medical care, the situation is easily resolved, but for those who do not, the road to receiving dental care is often fraught with frustration and difficulty. This state of affairs is not helped by the United States being the only industrialized country without universal health insurance³⁰; this, while even some developing countries, such as South Africa, are examining ways to introduce universal health insurance to its population.^{31,32} While it certainly improved the state of affairs in the United States, the Affordable Care Act of 2010 still leaves millions without health insurance.³³

Based on the ADA Code, therapeutic alliance, and virtue ethics, Dr V has a duty to advocate on Mr S's behalf and to encourage him to seek and pursue treatment for his hypertension and health care generally. She should endeavor, independently of Mr S's efforts, to find a physician able to treat him. If, despite reasonable efforts on her part, Dr V is unable to secure medical care for him, she cannot be held responsible for society's choice, acting through its elected representatives, to forego universal health insurance or for Mr S's choice to forsake medical care even when it is available to him.

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Editor's Note

The case to which this commentary is a response was developed by the editorial staff

Citation

AMA J Ethics. 2022;24(1):E6-12.

DOI

10.1001/amajethics.2022.6.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

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