

# The ethical debate between what patients want, need and can afford, and what treatment clinicians think they should receive

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## ABSTRACT

Endodontic emergencies are common procedures in dental practice, and need to be addressed as soon as possible. The initial treatment is usually extirpation of the pulp – also known as emergency root canal treatment (ERCT), – followed by complete cleaning, shaping and obturation of the root canal system. Root canal therapy (RCT) needs to be completed with a definitive restoration to increase long-term prognosis of the tooth. Both of these carry additional costs. Patients treated in government facilities often have limited access to follow-up care due to long waiting lists, financial constraints or logistical challenges.

It is also difficult to determine how many patients return for these procedures as some who remain pain-free and asymptomatic may not see the need for any further treatment. Others may experience complications necessitating extraction of the tooth. The prognosis of unrestored extirpated teeth is unpredictable and literature is scant, thus dentists often need to make a judgement call when deciding between trying to save a tooth and recommending an extraction. This paper debates the ethical issue of considering patients' wants and needs, versus what clinicians think they should receive, as well as the issue of paternalism, in relation to the informed consent process.

## Introduction

Endodontic emergencies are common in dental practice, and can result from many different conditions of the pulp or peri-radicular tissues.<sup>1</sup> Endodontic emergencies need to be addressed as soon as possible especially if the patient is in pain or has signs of active infection. Accurate diagnosis and differential diagnosis is essential for proper treatment planning and correct medication.<sup>1</sup> In a study by Farmakis et al. (2016), the authors reported that the highest prevalence of emergencies at their clinic was, in fact, endodontic

conditions. Of these almost 48.8% had either reversible pulpitis, irreversible pulpitis and/or acute apical periodontitis, and as such the most frequent treatments performed were pulpectomies and abscess drainage.<sup>2</sup>

Endodontic emergencies may occur prior to endodontic treatment, during active treatment (usually root canal treatment or re-treatment) or at any time after root canal completion.<sup>3,4</sup> The success rates of emergency root canal treatments conducted without completion can vary. While these treatments generally provide relief from pain and infection their long-term effectiveness remains uncertain. Several factors like patient compliance, variation in operator skill, temporisation and state of the tooth, among others, contribute to this uncertainty. The provision of emergency root canal treatment without completion raises concerns. Dentists must carefully consider the need for pain relief as well as ensuring the long-term wellbeing of their patients.

This scenario brings attention to the predicament confronting healthcare professionals especially those working in busy practices and government healthcare facilities that have limited resources. While it is crucial to relieve pain and suffering it is equally vital to educate patients about the importance of completing follow up RCT for the long-term survival of teeth.

This paper will explore the clinical and ethical issues a dentist needs to consider in patients presenting with pain, sepsis, swelling or irreversible pulpitis and requiring emergency pulp extirpation (ERCT).

## Considerations

When carrying out an ERCT, the understanding is that the patient will return for completion of the RCT as well as have some form of permanent restoration placed. Both of these carry associated time and costs. However, it is very difficult to determine how many patients do return for the definitive procedures. Once the symptoms have subsided, some may not see the need to have any more work done. Some may not be able to afford the subsequently recommended procedures, while others may only return if the tooth flares up or becomes symptomatic. Following ERCT, a tooth's behaviour and prognosis is unpredictable. Complications may occur at any time, from days to years later. When this happens, some patients may go back to the dentist who saw them initially, while others could seek help elsewhere. Depending on the time lapse and the state of the tooth it may still be possible to complete the RCT and restore it, or it may have broken down to such an extent that an extraction is necessary. Furthermore, some patient may themselves

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rather opt for an extraction than go through with all the visits needed to save and restore their tooth. Thus, there are a number of clinical, patient-related, clinician-related and ethical factors a dentist needs to consider before embarking on an ERCT in patients who present as emergencies with pain, sepsis, swelling or irreversible pulpitis.

#### Clinical factors

Following a detailed and specific medical, dental and radiographic evaluation the dentist will have to look at the tooth in question and determine if it is saveable. If not then treatment will include pain relief, control of sepsis and infection, and immediate or delayed extraction. Clinicians should further assess whether in fact it is beneficial in the long term to retain this tooth in question. What is its position in the arch, how many other teeth are present, is it necessary in terms of masticatory function, speech, aesthetics or as an abutment tooth for some other prosthesis, what sort of restoration will be needed after completion of the RCT and if, in fact, endodontics will be possible based on radiographic evaluation of the canal/s. They should also assess the patient's oral hygiene status, number and condition of existing restorations, and treatment needs of the remaining dentition, mouth opening, gag reflexes and if the placement of rubberdam or proper isolation is possible.

#### Dentist factors

The clinicians faced with a tooth that requires an ERCT must make an honest appraisal of whether they have the skills and armamentarium necessary to complete that particular RCT, and subsequent restoration, or if they will need to refer to a specialist. If the latter, then the patient needs to be made aware of this as it may have time, access and financial implications for them. They also need to weigh up the feasibility of trying to save the tooth in terms of time, cost, pain and discomfort to the patient, versus its anticipated outcomes. A complex, lengthy and costly procedure in a tooth with a poor prognosis is difficult to justify unless that tooth is of crucial importance within the stomatognathic system. The dentist should then explain to the patient the procedures and number of visits that will be required following ERCT, in order to have the RCT completed and a permanent restoration placed. They should provide estimated time and costs involved and caution the patient that there is a possibility of complications, such as root perforation, tooth fracture or subgingival caries resulting in extraction at a later stage. Alternative treatment options should be discussed, including details of the advantages and disadvantages of each. Finally, they should give an unbiased opinion as to which will be the best and most suitable treatment for their situation.

#### Patient factors and paternalism

The patient, who is now informed and educated, should then be asked what exactly they want. At this stage the clinician needs to give the patient time to communicate, ask questions and deliberate. They should not be tempted to rush through this process or interject with their opinions. It is also important to remember that a patient who is in pain is already in a compromised and vulnerable state, and may need more time and support to help them make a wise decision. Of course, what a patient wants may not be the same as their needs, and may not be possible, desirable or feasible for them in that situation. However, the clinician needs to caution against deciding for the patient based on "their own" opinion of what is best for the patient. It is here where an ethical issue may arise. If after having carried

out a similar clinical evaluation and patient assessment to that outlined above, the dentist considers the tooth to be saveable and restorable, but has doubts as to whether the patient will return for the required completion visits, what should they do? One would have to ask, how did they come to this decision? Was it based on a personal judgement call which could have been erroneous or even biased and prejudice?<sup>5</sup> Do they have the right to make assumptions about another person's future behaviour? Are they acting in the patient's best interest or from a self-assigned moral high ground? Should they try to impose their views? Could that be considered paternalistic, and would it be ethically defensible?

Paternalism refers to a situation where "the clinician disregards the patient's opinion and decides on/or refuses treatment unilaterally".<sup>5,6</sup> Soft/weak paternalism generally refers to those situations where the doctor truly believes they are protecting the patient from the consequences of an unwise decision. Other subtle forms may be where they exaggerate the risks and costs of the procedure they don't wish to perform, and downplay these in the treatment they are advocating in order to coerce the patient into accepting their suggestions. They may also purposefully not give the patient too much information, because they have decided that the patient will either not understand it all, does not need to know the details or will not be able to cope with hearing about possible risks or adverse events. Soft paternalism is easier to justify where it is seen to prevent harm, where it will result in perceivable benefits to the patient and where risks to the patient are low.

Hard/strong paternalism is when the practitioner tries to enforce their views based on "differing personal values and goals, fear of litigation, where they feel incompetent to carry out a procedure, or where there is a conflict of interest".<sup>5-7</sup> It is much harder to justify, and more so when the risks to the patient are greater.

## DISCUSSION

Given the unpredictable behaviour and unknown prognosis of teeth that have undergone an ERCT without ever having the RCT completed the dentist often needs to make a judgement call when deciding whether to extract or try to save a tooth when patients present with an endodontic emergency. However, before making any final decisions they need to engage with the patients to ensure they provide them with the three core features of informed consent, these being threshold, information and consent elements. In an emergency situation the threshold element of time to consider the options may be limited, but the principles of competence, understanding and voluntariness will still apply. With regard to the information element, the practitioner should not be tempted to make personal judgement calls as to whether the patient deserves to have the tooth saved, and must disclose all the relevant information in an impartial manner. They should also then present the patient with all possible treatment plans but may propose the preferred/most suitable option.

A slightly different situation arises in high patient turnover and resource-limited settings such as government hospitals and rural clinics. Here the numbers of patients who present with emergency endodontic problems often far exceeds the staff or facilities' capabilities of providing timely definitive treatment. Many patients who undergo ERCT procedures find themselves on long waiting lists, and may discover that

by the time they are recalled, the tooth has deteriorated to such an extent that it is no longer possible to save it. The ethical question is now not about refusing treatment for paternalistic reasons, but rather about considering distributive justice. Should limited resources be used to provide a treatment that requires many follow-up visits and costly interventions, which may never materialise. Would it be better to advise the patient to have the tooth extracted and be placed on a waiting list for a partial denture? Not only may this be the more “appropriate” option<sup>8</sup>, but they may be treated sooner, in fewer visits, it requires less invasive procedures, is cheaper and may be the ultimate treatment in any event.

However, they still need to respect that fact that an informed patient may want to “take a chance and buy themselves some time”, which can vary from a few days to years, by undergoing the ERCT. In this event, they must keep clear records of the conversations and advice given, and the patient’s acceptance of the risks.

### CONCLUSION

The final decision about any medical or dental treatment must be made by the patient. However, for them to make an informed choice they need to have been guided by

the clinician who should have provided them with enough knowledge to ensure they understand the information, proposed plans, consequences of accepting or refusing treatment and all possible alternative options. If they opt to undergo an ERCT, they should also commit to completing the RCT and subsequent restorations, ensure they have the necessary finances and time, and be aware of the limitations and possible complications of these interventions. They must then make the final selection and provide autonomous, voluntary authorisation and signed informed consent.

### REFERENCES

1. Abbott PV. Present status and future directions: managing endodontic emergencies. *Int Endodontic J.* 2022;55(suppl.3):778-803
2. Farmakis ET, Palamidakis FD, Skondra FG, Nikoloudaki G, Pantazis N. (2016) Emergency care provided in a Greek dental school and analysis of the patients’ demographic characteristics: a prospective study. *International Dental Journal*, 66, 280-286
3. Carrotte P. (2004) Endodontics: part 3. Treatment of endodontic emergencies. *British Dental Journal*, 197, 299-305
4. Azim A, Azim K, Abbott PV. (2017) Prevalence of inter-appointment endodontic flare-ups and host-related factors. *Clinical Oral Investigations*, 21, 889-894
5. Sykes LM, Van Zyl AM, Harris A. Refusing to treat. Is it legal? Is it justifiable? Is it ethical? *SADJ April 2023, Vol 79 No 4:217-219*
6. Sykes LM, Evans WG, Cooke HA, Dullabh HD, Herbst D. Informed Consent. Part 16: It’s more than a matter of “Been there, done that, got the signature”. *SADJ 2017*
7. Beauchamp T, Childress AF. (2001) *Principles of Biomedical Ethics*. Ed. Oxford University Press, New York
8. Sykes LM, Kok J, Nethononda PT. Does providing “Compromised treatment” equate to “Compromised care” or could it be considered “Appropriate”? *SADJ July 2023; 78; 5; 321-322*

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