Treating Patients with Addictions, Part One

Considering the Partially Capable or Partially Incapable Patient

Practicing dentistry ethically is often easy. For the experienced professional, practicing ethically is rarely challenging when the patients in care value their oral health, and value and support the patient-professional relationship. This is especially so when oral health needs are fairly typical and the resources for oral health care are sufficient to meet patient needs.

However, a clear challenge to practicing ethically is presented when the dentist suspects a patient is seeking assistance in supporting an addiction. Most dentists have found themselves in this scenario at one time or another. A patient new to your practice enters your operatory saying the following:

"Thank you for seeing me, doctor. You're so kind to see me. I know you're busy and I don't want to take up your time. My regular dentist isn't available and I can't take this pain anymore; it's mostly in my back teeth and has been going on for a long time. He is not sure what it is and he may need to start a root canal when I see him next week. I have gotten a lot of relief from something my doctor gave me, but I forgot the name—I think it started with a 'p'; they were 10-milligram pills. He gave me enough to 'hold me over,' as he put it, 'til we figure out what's really wrong.' He's away this week, and I was hoping you could just prescribe something so I can handle this pain till he gets back."

What should you do? Is this complaint real? Should you investigate more? Should you turn the patient in right now? And, if so, to whom should you report him? Should you lie to the patient and say, "I'm sorry, I am not taking any new patients right now. The receptionist will give you a list of other dentists in the area." However, your scheduling book is empty for the rest of the afternoon. Should you just give the patient the prescription he wants, or perhaps something weaker than what he asked for? That will at least get rid of the patient … right?

Should you explain that you need to do an assessment before you can act and put the patient in the chair for an examination? And if you find no plausible physiological explanation for the patient's pain, should you then provide him with the prescription "just in case" his pain is genuine but as yet undiagnosed? Or should you assume that such a person—with unconfirmed claims of oral pain—has an addiction? And, if this is your hunch, or even your best guess, then what can you do?

The ethical questions that arise regarding patients who might be seeking our assistance with addictions fall into two categories that are closely connected but require separate examination. One category concerns the decision-making capacity of a patient with an addiction. The other consideration is how a dentist ought to interact with such a patient. What the dentist ethically ought to do (and what the dentist ethically ought not do) depends on how one views such a patient's capacity for decision-making.

The capacity for decision-making

With the exception of the children in our lives, most of us interact with people whom we consider to be fully capable decision-makers. We may think that some of them make unwise decisions, but we do not doubt their capacity to make those decisions. It is, in fact, this very basic capacity for decision-making that a dentist gauges in each patient as he establishes a relationship with the patient before making any determinations about treatment. If the patient is a capable decision-maker, then ethically, decisions must be made collaboratively with the patient. This fulfills the minimum requirements of informed consent, and ideally, involves a much greater measure of shared judgment and choice. So how can a dentist determine whether or not the patient has the basic capacity for decision-making?

Even though it is natural today to say that people who meet this standard (the one just described in the previous paragraph) are fully capable, we know that what we really mean is that they are capable enough. We (the authors) have to admit that, if we take the expression "fully capable" literally, we ourselves only occasionally meet that high of a standard even though we are "capable enough" during most of our waking hours. We assume that our readers view themselves similarly. Even among the hundreds of people a person meets every day whose capacity for decision-making is clearly not compromised in any significant way, there are

degrees of decision-making capacity. What we encounter most often in ourselves and others, then, is not full capacity, but rather being capable enough.

Capable enough for what? Capable enough that other people ought to respect that choice. If a person's ethics (or the ethics of a professional role) include being respectful of the value of autonomy (sometimes also called "freedom" or "liberty"), then when a person capably makes a choice—one that is his or her choice to make—that choice deserves others' respect. As mentioned already, this does not necessarily mean such a choice was the product of good judgment, or that anyone thinks such a choice was the product of good judgment—those are separate questions. Nor, to be clear, respecting someone's choice may not necessarily mean that one must refrain from resisting the effects of such a choice. The value of choosers' choosing, in the sense of controlling their own lives (when they are capable enough to do so), is of high value in our society. And, in some ways, even more importantly, it is of high value in the ethics of every profession in our society.

Capable enough about what? The key phrase in answering this question is the matter at hand. There are many things that we are not capable enough to make decisions about due to lack of necessary information, but this lack of capacity in other areas of life is irrelevant unless the needed information concerns the matter at hand. Other kinds of deficits in decision-making—developmental, physiological, emotional, or psychological—are similarly irrelevant if they have no impact on a person's capacity to decide the matter at hand.

There are patients who are capable of managing large corporations, but who are, because of great fear, not capable of choosing to undergo root canal therapy. Some patients' global capacity for decision-making may be sufficiently compromised so that the burden of proof would lie with anyone who judged them capable enough to decide on a particular treatment. But even in such cases, the patient's global capacity is only indirect evidence for what is always the focal question about decision-making capacity: Is the patient capable enough to decide the matter at hand?

People who are simply incapable

So imagine a line with a continuum of degrees of decision-making capacity: full capacity at one end of the line and no capacity at the other. Somewhere between the midpoint and the full capacity end of the continuum, then, is the threshold marking capable enough. Now look at the other section of the line. Here are those people who are simply incapable. Some of these people will be simply incapable for developmental reasons (infants, very small children, and people with profound congenital cognitive deficits, for example). Others, whose profound cognitive deficits were acquired at some point in their adult lives, were at one time capable decision-makers. For others, their deficits are not congenital but were acquired before they ever became capable enough. And, some of the people who are simply incapable will be those persons whose deficits are either likely temporary or of uncertain duration (for example, people who are presently unconscious and/or otherwise rendered incapable of decision-making by disease, profound emotional illness, or medications).

Just as there are clear ethical guidelines for the dentist's ethical interactions with a capable enough patient, there is also a wide consensus about how health professionals ought to make treatment decisions regarding simply incapable patients. Of course, dental and health professionals frequently deal with such patients in practice in the context of fairly specific legal requirements. Those requirements typically identify a legally authorized proxy to make decisions about the simply incapable patient. But from the standpoint of ethics, the broad consensus about the ethics of treatment decisions for simply incapable patients applies as strictly to the legally authorized proxies as it does to the health professionals caring for such patients or anyone else involved in the decision-making process.

This consensus about what ought to be done for a currently simply incapable patient consists of two principles and it is important to note that the second one is to be acted upon only if the first one cannot:

- **Principle 1:** Do whatever the patient would capably choose, among the alternatives available in this situation, if he or she were currently capable (i.e., do what he or she would choose if capable based on the evidence available from his or her previous relevant directives, statements, choices, etc.), with the proviso, however, that such evidence both points clearly enough toward a particular way of acting in this situation, and is dependable enough that a reasonable person, who cares about this patient, would consider it ethical to act on it.
- **Principle 2:** If acting on Principle 1 is impossible (because of the inadequacy of the evidence or its pointing inconclusively in multiple directions regarding the situation at hand), then do whatever is in the patient's best interest, as judged to the best of their ability by the relevant decision-makers, which will include the patient's primary caregiver and the legally authorized proxy, as well as other parties who might be involved in the decision.

It is important to note first that Principle 1 says to do "what the patient would choose." This can be determined, however, only in relation to a condition that does not exist (i.e., a condition of "if he or she were currently capable"). That is why an explanatory comment is needed about what to use as evidence for judging what this patient's contrary-to-fact choice would be.

Obviously, evidence for such a thing will often be, at best, only mildly conclusive. But sometimes it will be conclusive enough. That is, it will be conclusive enough that a reasonable person, who cares about this patient, would be willing to act on it. And that is all we can ask. However, it is precisely what ought to be asked of the health professionals involved, or of legal proxies, or of anyone else involved in decision-making for someone simply incapable.

Second, note that the determination of the patient's best interest in Principle 2 is explicitly identified as a judgment

of the relevant decision-makers. If we knew what the patient would now judge is in his or her best interest, then we would almost certainly have been able to act reasonably on the basis of Principle 1. But the guidelines here clearly say it is ethical to act on the basis of Principle 2 only if it is impossible to act on the basis of Principle 1. This does not mean, of course, that the relevant decision-makers' own knowledge of the patient's values, fears, etc., cannot be part of his or her decision-making process on what is in the patient's best interest, even if this knowledge of the patient is not sufficiently conclusive or clear enough to act on the basis of Principle 1.

Partially capable and partially incapable

Now picture again the line of continuum of degrees of decision-making capacity introduced above. There is another area on the continuum line—the section that lies between the thresholds that mark the end of the simply incapable section and the beginning of the capable enough section. It is important to ask if there are persons whose capacity for decision-making is best described as being in this middle section of the continuum.

There certainly are. Most patients, in fact, begin their encounters with health care professionals in this middle area; this is because they do not know enough, initially, about their bodies (including the oral cavity) to discern whether they need treatment or, if they do, what kind of treatment they need. They are partially incapable because they lack the information a person needs to make a capable (enough) decision about treatment. But when they have been provided with the proper information in an appropriate way, they can then become capable enough (or perhaps, fully capable) decision-makers about their care. So there certainly are patients who are, at least temporarily, simultaneously partially capable and partially incapable.

Unfortunately, some patients remain partially capable and partially incapable. For example, some patients do not succeed in understanding what the dentist is trying to explain to them about the condition of their oral cavity. Explanations can be given again and again, using every educational skill and tool available, and still the dentist cannot reach the point at which the patient can be said to be adequately informed to make a capable enough decision. What then? What ought to be done about decision-making for patients who are partially capable but also partially incapable in such a way that the caregivers involved are unable (after extensive and careful efforts) to correct their partial incapacity for decision-making?

Before answering this question, it is important to mention some of the other kinds of partial incapacity. There are patients whose decreasing cognitive capacity (e.g., from partial dementia) has rendered them no longer capable enough as decision-makers but yet not simply incapable either. They may understand the value of good oral hygiene and regular dental exams and be very positive about being in the chair but not understand the fact that their gums are diseased and specific periodontal treatments are needed. There are patients whose understanding of their oral health needs and the appropriate treatments is completely adequate but whose emotional or psychological state leaves them unable to complete the necessary process of decision-making regarding their care.

And there are patients who, under mild sedation, seem completely themselves and can carry on perfectly coherent conversations but whose ability for decision-making has nevertheless almost certainly been compromised, so they are best judged to be not capable enough. Experienced practitioners will be able to add other kinds of examples to this list.

Again, the key question about a patient's decision-making capacity is how capable he or she is of making a decision about the matter at hand. Although patients' ability to understand and make decisions about other matters may offer evidence of their global decision-making capacity, this is, at most, indirect evidence about their capacity for decision-making about the matter at hand. It is always ethically essential that the final judgment about whether a patient is capable enough or not is a judgment about their capacity regarding the matter at hand.

Now let us return to the previous question. What is the ethical thing to do about decision-making for patients who are partially capable but also partially incapable in such a way that the caregivers involved are unable (after extensive and careful efforts) to correct their partial incapacity for decision-making about the matter at hand? In spite of its clear importance for health care providers (many of whom see a much larger proportion of partially capable and partially incapable patients than most dentists do), this question has barely been discussed at all in the literature of health care ethics.

We believe that it would be unethical to treat a currently incapable-about-the-matter-at-hand patient as if he or she were a capable decision-maker. If such a patient were to choose something to his or her detriment, there are very few people who would judge a dentist, or any other health professional, favorably for acting on a decision that the dentist believed was being made by someone who was not capable enough of decision-making in that matter. Therefore, on the basis of the two principles explained in the previous section, we believe decision-making regarding a patient who is partially capable and partially incapable, but definitely not simply incapable, should be made as if the patient were simply incapable.

It is still important to stress, though, that the partially capable and partially incapable patient is not someone who is simply incapable. This notion can be hard to grasp. For even though it is easy enough to envision the capacity for decision-making on a continuum, and to describe the differences between fully capable, capable enough, and simply incapable in terms of this notion, many people may still find the concept of someone being partially incapable very puzzling. In fact, the question might be: "Wouldn't it make more sense to say, for example, that these are patients who are currently incapable, but whose deficit is correctable?"

There are two reasons why this description of such patients would be seriously inadequate. First, it presumes that the patient's deficit is definitely correctable, and that is

not always the case. To fix this aspect of the description, we would need to say something like "in principle correctable," but what would that mean? Or, perhaps, we might say that "there are standard methods of correction to be employed" with such patients' deficits, and that is ordinarily true. But now we are no longer talking about characteristics of the patient but rather about possible characteristics and capabilities of the caregivers dealing with the patient.

Second, and more importantly, by describing such patients as being both partially capable and partially incapable, we are stressing that they are still partially capable. And that is extremely important in practice, because it is a reminder that they themselves may be sources of evidence—though not conclusively so (since they are also partially incapable), but certainly relevantly so. If such patients were described in a way as to stress only their partial incapacity, a very important part of who they are and what they are capable of would be left out of our consideration in general and it would be very easy to exclude the contributions that they themselves might potentially make in the actual decision-makers' applications of the two principles.

In summary, the first ethically required response to a partially capable and partially incapable patient is to attempt to correct the patient's deficit(s) in decision-making capacity. This will first require a diagnostic step—various possible deficits in decision-making capacity will need to be reviewed in terms of the patient's ability to address the decision at hand until, at least ideally, we know the kinds of deficit(s) the patient is suffering. Then, a focused effort, and sometimes also repeated efforts, will be required to correct this deficit with the aim of bringing the patient to a point of being at least capable enough to address the decision at hand.

If these efforts are unsuccessful, though, our proposal here is that health care decisions regarding a patient who is partially capable and partially incapable, and whose deficit(s) cannot be corrected by means of the resources that are available, must be made in accord with the two principles above. Decisions must be made as if the patient is simply incapable. But because the patient is definitely not simply incapable, his or her input must, to the extent possible, be sought.

Judging a patient's capacity for decision-making

Few dentists, and few professionals in any health field, consciously stop to look for markers of a patient's decision-making capacity, that is, unless a "red flag" goes up to suggest that there might be some deficit of capacity in the patient. When careful judgments of capacity are needed, though, a set of criteria—the signs of capable decision-making—are also needed.

There is a great deal of literature on this topic. About half of it is work by psychologists and ethicists working together to identify relevant criteria. The other half is legal literature on the legal categories of competence and incompetence, which we will omit from this discussion not only because their focus is on capacity to make decisions that are legally valid rather than ethically significant, but also because these legal categories do not allow for any middle ground.

For brevity's sake and to avoid a still more complicated analysis, we reproduce here the five criteria of capacity for decision-making offered in "Dental Ethics at Chairside":

1. The ability to understand the relationship of cause and effect
2. The ability to see alternative courses of action available for choice and to choose between them
3. The ability of a person to conceive of herself or himself as one who can choose between the alternatives in a given situation
4. The ability to reason comparatively about the alternative courses of action to reach an ethical judgment about them
5. The ability to form and choose values, principles of conduct, and personal ideals to guide one's moral judgments and to shape one's moral reflections and conduct accordingly

Note again, that it is the patient's ability to do these five things specifically with regard to the matter at hand that is relevant to judging whether a patient is capable enough to make a decision about it.

This essay has focused entirely on the topic of decision-making capacity and the ethical standards to be employed in making treatment decisions regarding patients who are not capable enough to make a treatment decision on some matter at hand. But what set us off on this path was the question of how to deal with a patient who may be seeking assistance in supporting an addiction. In order to discuss the ethics of dealing with such patients, it will first be necessary to examine the question of how capable an addicted patient is to make decisions that impact his or her oral and general health.

The next article in this series about patients with addictions will begin at that point and discuss the complex ethical questions about how to deal with such patients that depend, in significant measure, on the dentist's best judgments of the patient's decision-making capacity. ◆

Donald Patthoff, DDS, MAGD, is a general dentist who has practiced in Martinsburg, W.Va., since 1974. He has been a member of the American Society for Dental Ethics (ASDE), formerly known as Professional Ethics in Dentistry Network (PEDNET), since 1988, and has served as its president. He served as chair of the Ethics Committee of the Academy of Laser Dentistry from 1996 to 2003 and since 2006, and has been a member of the American College of Dentists ethics committee since 2001.

David Ozar, PhD, is professor and co-director of graduate studies in health care ethics in the Philosophy Department of Loyola University Chicago. He is an Honorary Fellow of the American College of Dentists, and was the founder and first president of the American Society for Dental Ethics in 1987. He served as president again in 1998, as its unofficial executive director from 1989 until 1993, and formally as its executive director from 1999 until 2005.

COMMENT