Talking Ethics

Ignorance of Frailty and Palliative Oral Care

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Ignorance of palliative dental hygiene oral care (PDHOC) is an ethical issue because it may lead to inadequate care and unnecessary suffering. When health care providers or caregivers are unaware of the importance of appropriate oral care techniques, inadequate or substandard care can result. Clients, patients, and/or residents of long-term care homes may experience pain and discomfort, which are both avoidable and ethically problematic.

PDHOC is provided when a person becomes dependent on others for care. PDHOC focuses on reducing the severity of oral symptoms, preventing pain, and maintaining cleanliness and comfort in the mouth through to the end of life.[1] Providing PDHOC aligns with CDHA's ethical principles of beneficence (doing good) and non-maleficence (doing no harm) by promoting the well-being of the person and preventing needless suffering.[2]

Oral care is currently a hot topic in the media with the introduction of the federal government's national dental care program, which is initially focussed on supporting children under the age of 12. Huge gaps remain in oral care for frail seniors and persons with disabilities. There is a serious lack of recognition of the role of dental hygienists in palliative oral care and in society.

Ignorance abounds among the public and politicians. There is a general lack of knowledge and understanding of the importance of the oral microbiome.[1] Sadly, the cleanliness of the mouth and the role of the dental hygienist are often overlooked. Oral care of persons in the palliative and end-of-life stages is frequently inadequate. Dental hygienists have a vital role, responsibility, and ethical obligation to address ignorance and share knowledge of the importance of PDHOC, cleanliness, and comfort of mouth.[1,3]

Older persons are a growing demographic. By 2031, one in four Canadians will be over the age of 65. Advances in medical science and clinical practices have resulted in people living longer.[4] Persons of any age can experience health changes and frailties. Frailty is the physical weakness, lack of health or strength that happens with aging and/or disabilities. Physical and cognitive deficits associated with frailty lead to increased dependence on others for activities of daily living, including oral care.[1]

There is general ignorance about how frailties directly or indirectly affect oral health care. As frailty progresses, oral self-care frequently becomes difficult or impossible. Dental hygienists must recognize how frailty impacts oral care (Table 1).[1]

It is critical for dental hygienists to determine the appropriate choices for dental hygiene therapies. Dental hygienists need to apply their knowledge of and expertise in non-invasive interventions to address unmet oral health needs. PDHOC therapeutic services include frequent non-invasive debridement and interim stabilization therapy. Non-invasive debridement is the removal of any soft deposit—biofilm, plaque, food particles, pathogens—that may cause inflammation and strain the body's ability to fight infection. All areas of teeth and gingiva, focusing on the tooth-gum interface and embrasures, are cleaned using oral hygiene tools (e.g., toothbrush, floss, proxabrush, interdental stimulator), not scalers, curettes, ultrasonic or aerosol generating tools. Traditional clinical debridement with scalers is inappropriate and often unsafe.[1]

Ethical issues arise when PDHOC is not readily available to frail and/or vulnerable populations. Numerous barriers exclude dental hygienists from providing PDHOC. Preventive oral care is seldom valued by the public and policy makers. Legislation does not require dental hygienists to be on health care teams. Persons face financial, access, geographic and transportation barriers to care. Public health programs frequently have restrictive access criteria. Oral care standards in legislation and regulations are often ignored. Daily oral care is assigned to health care workers who lack education, training, and experience working in the mouth.

Table 1. Impacts of Increased Frailty on Oral Health
➤ Xerostomia/salivary hypofunction
➤ Hypertenacious oral biofilm
➤ Elevated risk of caries from inadequate buffering capacity of saliva
➤ Elevated risk of mucositis, gingivitis, and candidiasis
➤ Difficulty expressing complaints
➤ Resistance to oral care and treatments
➤ Disregard/disinterest in oral care
➤ Inability to follow treatment regimens
➤ Impaired ability to perform oral hygiene
➤ Intolerance to dentures
➤ Difficulty seeking oral care and treatments
➤ Limited financial and social resources for oral care

▲ *Adapted from: MacEntee MI, Donnelly LR. Oral health and the frailty syndrome. Periodontology 2000. 2016;72(1):135–41.*[5]

Dental hygienists must reduce ignorance by advocating for improved palliative oral care.

- Advocate for persons to receive appropriate and competent PDHOC.
- Recognize the signs of frailty and the cognitive and physical limitations of oral self-care.
- Educate persons and their families about the importance of PDHOC.
- Educate and train caregivers about the proper assessment and care of the oral cavity.
- Connect persons to dental hygienists in independent practice who offer PDHOC.
- Recommend simple and inexpensive palliative oral care options and assistive oral care devices.
- Collaborate with health care team members to recognize oral problems, the importance of PDHOC, and when to refer to dental hygienists.
- Work with administrators and nursing staff to establish the dental hygienist's role in community care settings.
- Lobby politicians, legislators, and policy makers to include dental hygienists in legislation as essential health care providers on palliative care teams in all health care settings.

According to the ethical principles of beneficence and nonmaleficence, dental hygienists have a responsibility and obligation to educate and advocate for the needs of the palliative care patient. It is paramount that dental hygienists learn and understand the need for palliative dental hygiene oral care from the time of increasing frailty through to the person's end of life.

References

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