Ethics in an Aging Society: Challenges for Oral Health Care

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Abstract

Health and aging are deeply meaningful and complex realities. The demographic reality of the Canadian population in the 21st century requires an in-depth understanding of the health care goals of older people, an analysis of the attitudes toward older people that affect societal decision making and the educational and policy changes required to effect positive change. Viewing these issues through the lens of oral health care allows an analysis of health care goals for the older population. A look at representative cases where oral health needs were not met uncovers some of the attitudes and values about oral health, the goals of health care and the unique circumstances of older people that present barriers to appropriate care.

MeSH Key Words: *aging; dental care; health services needs and demands/trends*

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Ethics is the discipline of philosophy that guides value-laden decision making and conduct. Health care ethics is concerned with the identification and investigation of ethical problems that arise in the increasingly complex realm of health and health services.[1] Ethical dilemmas occur when the right or good choice is not readily apparent.

Canada's aging population and the demands it is beginning to place on the health care system present some of these dilemmas. There is widespread belief that the aging of the baby boomer generation is creating an unsustainable pressure for services, especially health services. Older people have become scapegoats for rising health care costs. This attitude diverts attention away from serious reflection on the development of health care policies and practices in which fairness, respect and care for people of all ages are addressed. In a society dominated by the individual, it is essential that public policies reflect the importance of the common good.

Just and respectful health care for older people requires careful consideration of demographics, an accurate assessment of specific health care needs and an analysis of beliefs about older people and the aging process that affect clinical decisions and policy.

The Greying of Canadians

Accurate demographic and health status data are essential in assessing the greying of the Canadian population.[2] In 1991, Canada's population was 27 million; 3.2 million (11.7%) were over 65 years of age. By 2011, 14.1% of the population will be over 65 years, and there will be a substantial increase in the elderly (people over 80 years).

Health care utilization by older people generates enormous concern among researchers and health system planners. It is clear that hospital usage rises dramatically with age.[3] Nonetheless, older people are not high users of all types of health services, as some may assume.

Services utilization can be better understood from the perspective of health status than that of age. Using data from the 1994-95 National Population Health Survey, Rosenberg and Moore[2] assessed activities of daily living, the presence of chronic medical conditions and the perception of health status in older Canadians. One-third of respondents reported restriction in regular daily activity. Mobility, vision and hearing were significant problems for most people over 75 years of age, and beyond 70 years of age there was an increase in the number of people reporting more than one chronic illness. Despite these factors, 75% of respondents reported their health as good to excellent, and their use of physician services was only slightly higher than that of other age groups.

Developing meaningful health care goals for older people requires a rethinking of the balance between acute care services and this population's needs for chronic illness support, morbidity prevention, rehabilitation services and palliative care.

Respecting Our Elders

Fair and respectful health policy and practice require an understanding of the values that underlie our choices. Values are enduring beliefs that provide guidance for choice and action.[4] They are stronger and deeper than opinions; they are beliefs about what really matters. Both health and aging are deeply meaningful, value-laden realities, and clinical practice and health policy reflect these values and beliefs.

Health is more than the absence of disease. It is personal, physical, social and spiritual well-being. This holistic concept of health seems intuitively right. Its realization, especially with the progressive physical and, often, cognitive limitations of aging, is not always clear. Most of the important goals in aging are not related to cure but, rather, to optimal function. Healthy aging can be realized only if we accept it as a good to be desired and supported.

Science and technology have contributed to the changing status of older people in our society and have fostered belief in the ability of science to fix all human ills. The aging process is presented as another disease to be treated and cured. Limitations that once were accepted as a natural part of aging are now seen as symptoms requiring treatment.[5] Paradoxically, along with scientific advances that prolong life comes a radical shift in the value and importance of older persons and a devaluing of the aging process. The meaning, place and role of older people have changed. The view of these people as respected because of their wisdom and experience has altered, partly because their role in passing on moral and social tradition is not valued, and partly because the information age does not reward wisdom.

Aging, with its inevitability of decline and death, sharply focuses for caregivers, ethicists and policy makers the question of appropriate care. Callahan's suggestion that "medicine should be used not for the further extension of the life of the aged, but only for the full achievement of a natural and fitting life span and thereafter for the relief of suffering"[5] provoked criticism of an unjust ageism. Focusing only on lifespan can prolong morbidity and suffering without commensurate human benefit. On the other hand, age may be used as a discriminatory or exclusionary criterion. This use of age is unjust, but age can be the code for moral relevance in determining potential benefit, risk and harm.

The health goals of interventions in aging should be to decrease morbidity, to decrease disability and to increase participation and interaction.[6] These interventions commit health care to a respectful and compassionate use of science and technology with attention to the quality life issues that matter most to older persons.

Lessons from Oral Health

There has been a recent outpouring of dental literature about the older population on such topics as oral health indicators,[7] oral health status,[8-10] the financing, utilization and delivery of services,[11-13] analyses of barriers to care[10,11,14,15] and specific diagnostic and treatment concerns.[16] Recent attention has focused on the meaning and value of oral health for older persons.[17,18] A Canadian study[19] investigated the need to modify the curricula in dental schools to incorporate the geriatric population.

Because of Canada's aging population, oral health providers will see new patterns of need. A 1990 study[20] estimated that 80% of the institutionalized older population wear at least one denture, and 40% have some teeth. A 1997 study[9] involving volunteer subjects over the age of 50 showed that 78.6% of the subjects had teeth and 39.9% wore some type of denture. A direct comparison cannot be made between these data, but they may indicate a reversal in trends. Oral health providers will be required to address significant changes in treatment needs and respond appropriately to achieve the proposed goals for health care intervention.

The following three stories demonstrate that oral health function has an enormous impact on the health of older persons and emphasize the goals of meaningful care for older people.

Mrs. M is a 93-year-old who presented with her nursing home caregiver and a friend. She was frail and incontinent and had some signs of dementia. Throughout life she had attended a dentist regularly but as she aged and became less independent, her oral health care diminished. Her chief complaint on presenting was that her teeth were hurting and she therefore had difficulty eating. She had withdrawn from dining room and social activities and was losing weight. Examination revealed an inadequate and ill-fitting partial denture, poor oral hygiene and carious lesions on virtually all of her remaining 16 teeth. There were multiple necrotic pulp exposures.

Mrs. M's story is typical of many older people who require institutionalized care. She has no living family members and depends on the system for care and for advocacy. Her problem of simple dental caries was compounded when oral health was ignored. Withdrawal from the social life of the dining room was a profoundly important event, but it was not until she began to lose weight that oral health issues were addressed. Mrs. M suffered significant physical, functional and social harm before the appropriate diagnosis was made. Even when issues were identified, access to care was difficult because her nursing home did not have a dental clinic nor a regular dentist providing service. Treatment decisions were also challenging. She was not completely incompetent to decide about her own care, but respecting her choices required time and effort. Suffering and pain could have been prevented if adequate preventive and maintenance oral health care had been available to Mrs. M.

Mr. A is an 83-year-old with advanced Alzheimer's disease whose daughter arranged a dental visit to his nursing home for assessment of a broken front tooth. Mr. A had maintained his dentition and received a high standard of dental care before entering the nursing home. Along with the obvious coronal fracture of one of Mr. A's central incisors, assessment revealed multiple carious lesions, severe gingivitis and extremely poor oral hygiene.

Mr. A represents those elderly individuals who reside in a chronic care facility. His oral health was very poor, and even the most basic oral hygiene was difficult for caregivers burdened with high patient-caregiver ratios. The cost of care was not an

issue, and Mr. A's daughter had brought her concerns about oral hygiene to the attention of nursing home administrators. Unfortunately, as in Mrs. M's case, there were no facilities in the nursing home to promote preventive oral care or to provide treatment when necessary. After Mr. A had been examined, his cognitive deficit, frailty and general debilitation complicated treatment planning and implementation. Even basic oral hygiene was a major issue requiring expensive resources. Prevention and treatment for this growing high-risk group needs to be addressed in a new way.

Mrs. J, a 72-year-old patient, was seen at home to assess the recent loss of a post/core and crown. She was home-bound and oxygen dependent. She had a complete dentition and received regular dental care until one year prior to the home visit. The crown had failed due to recurrent caries. Carious lesions were diagnosed on eight more teeth in spite of her excellent oral hygiene practices. Her dentition was deteriorating as a direct result of dry mouth secondary to constant mouth breathing and medications that decrease salivary flow. Her heart and lung conditions precluded any form of invasive treatment to restore her dentition.

Mrs. J demonstrates the complexities of oral health care for older people who are chronically ill and technologically dependent. Mrs. J was competent, she lived in her own home, finances were not an issue, and she had home oxygen support for her cardiopulmonary disease. There was, however, a failure to consider the oral health sequelae of multiple prescriptions and chronic mouth breathing. Despite her deteriorating dentition there was inadequate attention to the prevention of occult odontogenic infections, which could have a serious impact on her general health. Oral health was simply not considered important. Once the problems were identified, Mrs. J's medical status precluded optimal oral health care intervention. Attending to the needs of medically compromised patients like Mrs. J requires creative palliative treatment options and an acceptance that ideal oral care may not be achievable.

Responding to Oral Health Needs

Many standard treatment options of modern dentistry are invasive, technologically complex, expensive and not available to nonambulatory older people who live independently or in a long-term care facility. Oral health professionals must develop treatment approaches appropriate for older patients and specifically focused on decreasing morbidity, decreasing disability and increasing interaction and participation.

The system for oral health care must change as well. Canadian surveys report that less than 20% of dentists have provided care to residents of long-term care facilities.[13,21] Also, a recent review by Hawkins describes the system of dental care for older adults in Canada as "patchwork quilt".[11] Although clinics for geriatric patients are being developed, treatment is provided almost exclusively in private dental offices. Services are paid for by individuals or private health insurance on a fee-for-service basis and "often the availability of care is due more to the unselfish actions of individuals rather than institutions."[11]

Oral health care services in Canada have long been considered discretionary; there is virtually no provision for publicly funded care. As a result, treatment for many older people is sporadic and sparse. According to Hawkins, this trend is not easily rectified, because of two major barriers. First, Canada cannot afford a "Denticare" program that would extend universal coverage to all older citizens. Second, the support of dental organizations for alternative care providers has been minimal and there has been opposition to alternative delivery systems such as managed care.[11] This issue presents an enormous ethical challenge to the oral health professions in terms of balancing professional autonomy and self regulation with a duty to recognize and facilitate much needed access to care.

Clear challenges are exemplified in the cases described. These challenges include the need for advocacy, especially for patients with cognitive impairment; the need to address limited and difficult access to care, especially for institutionalized older people; fair resource allocation; the development of age appropriate standards of care; and the need to reduce the marginalization of oral health in general.

There are at least four levels of response to these challenges.

First, individual care providers must be attentive to issues of ageism and the risk of discrimination against older patients. Individual professionals should support efforts to enhance access to care.

Second, the professions must undertake needs assessments and develop age appropriate standards of care that focus on realistic and respectful treatment goals. Organized dentistry should work to alleviate the marginalization of oral health care and develop strategies to overcome financial and physical obstacles.

Third, educators should model a range of practice patterns that include long-term care facilities and home visits. Meaningful research must be undertaken, and consideration of geriatric dentistry as a recognized speciality in Canada could be another positive step.

Fourth, the public should be actively involved in the review of policies and practices for long-term care facilities. The public should assist in the development of preventive oral health programs for older people and advocate to ensure that oral health issues are included in such studies as the National Population Health Survey.

Most high-profile ethical issues in health care have developed in the context of acute care because of advances in technology. Oral health can seem a small issue in the light of other more dramatic issues of aging. Nonetheless, focusing on the lessons learned through this lens of oral health can help identify the importance of the small things in function and well being. ❖

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