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ETHICS AND DECISION-MAKING IN THE DAILY PRACTICE OF ODONTOSTOMATOLOGISTS IN THE BOENY REGION, MADAGASCAR

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Abstract

According to Emmanuel et al, four conceptualmodels of medicaldecision-making have been identified: the paternalisticmodel,informative model, interpretative model and deliberative model. In Odontostomatology, the patient'srequest and the reason of their consultation represents a crucial factorsthat must betakenaccountwhilecreating the treatment plan and ensuring the intervention succes. The aim of thisstudywas to determine the decision-makingused by Odontostomatologists in the BoenyRegion, in Mahajanga, Madagascar, during oral health care. A qualitative sociological descriptive cross-sectional studywascarried out among 15 Odonto-Stomatologistspracticing in the BoenyRegion of Madagascar. It lasted 21 monthsfrom June 2019 to March 2021. Data werecollectedusing a formal qualitative semi-structured interview with a pre-established open-endedquestionnairy guide. Theyweretranscribed in Word version ; thenprocessed and analyzedwith Microsoft Excel and QDA Miner software. Fifteenodontostomatologistsfrom the Boenyregionwereinterviewed. They chose the paternalistic model, the informative model and the deliberative model for decision-making. The emergence of shareddecision-making in the face of patient autonomy has renewed the patient-practitioner care relationship. A patient surveywouldbe a welcome addition to thisstudy.

Key words :*therapeuticdecision, care relationship, ethics - patient care, Odonto-Stomatologists - oral health*

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I. Introduction

Medicaldecision-makingisdefined as the intellectualact of making a choicebetweenseveraltherapeutic options [1]. Four conceptualmodels of medicaldecision-making have been proposed by Emmanuel and colleagues: the paternalistic model, the informative model, the interpretative model and the deliberative model [2].

The evolution of thinking on patient rights has led to a shift in decision-makingauthorityfrom the practitioner to the patient. With the emergence of the Internet, and the multitude of health-relatedwebsites and other sources of medical information, some patients have felt more autonomous about theirhealth, usingpractitioners as simple“consultants” [3,4]. Currently, the concept of shareddecision-makingisaccepted and has legal justification [5].

This studywasundertaken to determine the decision-making mode(s) of Odontostomatologists in the BoenyRegionduring oral health care.

II.Methodology

Weconducted a descriptive sociological qualitative studyamong 15 Odontostomatologists (OS) practicing in RegionBoeny. The studyperiodwasconductedbetweenNovember 2019 and December 2020.

Weincluded all generalpractitionersregisteredwith the *Ordre Nationale des Odonto-Stomatologistes de Madagascar* (ONOSM) and the *Conseil de l'Ordre Régional des Odonto-Stomatologistes* (COROS), available and present at the time of the interview.

Purposive sampling wascarried out to select participants based on theirability to provide us with the information (in detail and depth) werequired.

Weconducted the studyusing a formal qualitative semi-structured interview with an open-ended questionnaire guide, each lasting 30 minutes. To manage certain doubtsconcerning the answers, weopted for “triangulation” by cross-checking certain questions in order to compensate for a certain level of insincerity on the part of the stakeholders.

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The data collectedwastranscribed to Microsoft Word as soon as possible and copied to Microsoft Excel and QDA Miner v2.0.7, where the analyses werecarried out. Ethicalconsiderationsweretakenintoaccount.

III.Résultats

In terms of the socio-demographic profiles of Odonto-Stomatologists, the male genderwas the mostrepresented in ourstudy, occupying 53.3% of interviewees, and 66.7% of all participants wereunder the age of 35. The averageagewas 32. Next, 86.6% practiced in the City of Mahajanga, District of Mahajanga I, capital of the BoenyRegion. Thesepractitionershad been in practice for at least a year, 40% of whomwereyoungsowith no more than 5 years' experience.

As fortheming, the decision-making process variedfrompractitioner to practitioner. On the one hand, somepractitionersdecided on theirownwhich intervention was best for their patient.

“At first, I decide on myown, even if the patient isn'talwayssatisfied... There are teethwecan'textractyet, like pulpitis and/or dentinitis, so I don'textract!”

Sometimes, theyimposed the decision.

“...for the patient'schoice, it'sstill us practitionerswho impose it.”

In this case, the patient had a passive rolesoheonly gave his agreement (agrément). "If the toothisstilltreatable, I'll talk to the patient about treatment, but if theydon'tagree, I'llsuggestthey go to anotherpractitionerwho can acceptttheirchoice.

On the other hand, somepractitioners let the patient decide; theyonlyproposed the therapeuticpossibilities of the present case.

"Yes, hedecides, I onlyofferhim the therapeuticpossibility of his case. I can't force him."

On the other hand, somedecidedtogetherwiththeir patients, but emphasizedwhattheyfeltwas best for the patients and steeredthemtowards the proposal best suited to their case.

"For me, regarding the decision, weshareittogether...I propose all the therapeuticpossibilities and hechooses. However, I emphasize one of theseproposalsthat I find best for his case, without pressure or forcing."

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Decision-makingalsovariedaccording to the clinical reality observed by the practitioner, the patient'specuniary situation and the influence of the employer, whoonlycared about the loss of earnings in theircoffers for a procedure not carried out with a patient.

"As for the decision, itdepends on the context. Sometimes, werealize the patient'sideabecause the proceduredepends on the patient'sfinancial situation and availability. For example, I had a case of a patient whosetoothwasstilltreatable, but hementionedlack of money and lack of time for furthertreatment. In the end, wedecided to extract the tooth."

"Weonly do what the patient wants, becausemy employer won't let the patient go home withouthavingperformed a proceduresolely for his or herownbenefit ».

IV.Discussion

- **Socio-demographic profiles of practitioners**

For the socio-demographic profiles of Boenypractitioners, the averageagewassignificantlylowerthanthat of French practitioners at 48.8 years [6]. Secondly, the high proportion of odontostomatologists in the region's capital wasreasonable, given the increasednumber of dental practices within the city and the presence of infrastructure, administrative and financial services, governmental and non-governmentalorganizations and industrial complexes that are alsoconcentratedthere. This maybe due to the factthatfamily and professional living conditions are easierthan in the countryside. Theseinclude running water, electricity and the various types of medicines and dental materialsthat are fundamental to the smooth running of a dental practice. In addition, the predominance of youngpractitioners has showntheirdynamism to becollaborators in research.

- **Analyse of the theming**

The decision-making process varies frompractitioner to practitioner.

- **The paternalistic or parental model**

On the one hand, somepractitionersdecide on theirownwhich intervention is best for their patient. They impose the decision. In this case, the patient plays a passive role, giving consent only. This type of medicaldecisionis part of paternalism [2]. In a paternalisticrelationship, the practitionerexercisesauthoritarian power over the patient

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and decideswhatis best for him or her, like a father for hischild [7]. However, itis no longer current to consider the care relationship as the meeting of the conscience of the caregiver and the trust of the cared-for. The concept of shareddecision-making has been adopted and islegallyjustified [8]. Shareddecision-making" beginswith a phase of neutral explanation of the diagnoses made in the previous phase [9, 10]. Then, the varioustherapeutic options are explained, again in a neutral manner, to help the patient understand and weigh up the various possible options [5].

- **The informative or patient-decision model**

On the other hand, somepractitionersonlyoffer the therapeutic options available in the current case and let the patient decide on theirowntreatment. This is an informative medical model. In a consumeristrelationship (informative model), itis the patient whodecideswhattheywant in terms of health, with the practitionerplayingonly an executiverole [7]. A prominentroleisthusgiven to the expression of informedchoices by patients, whobecomeactors in theirownhealth [11].

- **The disguised deliberative or paternalistic model**

Furthermore, some dental surgeons decidetogetherwiththeir patients whichprocedures to undertake, whileemphasizingwhattheybelieveis best for the patients and guidingthemtowards the mostsuitable option for their case. This represents a deliberativemedical model. Here, the practitioner not onlyinforms the patient of whatcouldbedone but, knowing the patient and hoping for the best for them, alsosuggestswhattheythinkshouldbedone. The practitioner and the patient engage in a discussion about whichmedical values the patient could and shouldultimatelypursue. This model may tend to resemble a disguisedform of paternalism. [12].

Moreover, the studyshowedthatdecision-makingalso varies according to the clinical reality observed by the practitioner, the patient'sfinancial situation, and the employer's influence. The latter, especially in private institutions, isprimarilyconcernedwith the loss of revenue in theircash-flow. Consideringthesethreefactors has also been unavoidable for Malagasy practitioners. This couldbeexplained by the deficiency of bioethics practice in the country. Indeed, the establishment of healthethicscommittees and the regularimplementation of continuingeducation on bioethics and dental ethicswouldbedesirable to promoteitsfield of application in Madagascar.

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Conclusion

In the end, our objective has been achieved as wewere able to determine the decision-making model(s) used by dental surgeons in the BoenyRegionduring oral care management. Consequently, we can inferthatthreemodels of medicaldecision-makingproposed by Emmanuel and hiscollaborators have been employed by the dental surgeons in the BoenyRegion: the paternalistic model, the informative model, and the deliberative model. The success of the proceduredepends on a good relationship and shareddecision-makingwith the patient. The implementation of thisshareddecision-makinghelpsprevent dental disputes in all aspects. Lookingahead, a study on the impact of decisions made beforetreatmentwith patients wouldbevaluable as a complement to thisstudy.

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