UPDATE

Oral health and vulnerabilities in palliative care in Uruguay: perspectives from Latin American bioethics

Salud bucal y vulnerabilidades en cuidados paliativos en Uruguay: perspectivas desde la Bioética Latinoamericana

Saúde bucal e vulnerabilidades em cuidados paliativos no Uruguai: perspectivas da bioética latino-americana

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DOI: 10.22592/ode2024n43e333

Abstract

Patients in palliative care face multiple dimensions of vulnerability (biological, social, moral and programmatic) that impact their well-being and generate different bioethical conflicts. Despite the prevalence of oral problems among these patients, dentistry is rarely integrated into their palliative care. **Objective**: Examine the different forms of vulnerability and how oral health care is addressed in palliative care in Uruguay, taking theoretical approaches from Latin American bioethics as reference approaches**. Methodology**: Narrative review. **Conclusions:** It concludes by highlighting the need to expand the interdisciplinary research agenda in this emerging intersection, investigating the perceptions of professionals and patients, to establish ethical guidelines that guarantee their rights and comprehensive dental care, considering the different dimensions of vulnerability.

Keywords: Palliative Care. Oral palliative care. Bioethics. Vulnerability.

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Received on: 27/dec/2023 – Accepted on: 16/apr/2024

Resumen

Los pacientes en cuidados paliativos enfrentan múltiples dimensiones de vulnerabilidad (biológica, social, moral y programática) que impactan en su bienestar y generan diferentes conflictos bioéticos. A pesar de la prevalencia de problemas bucales entre estos pacientes, la odontología rara vez se integra en su atención paliativa. **Objetivo:** Examinar las diferentes formas de vulnerabilidad y como se abordan en cuidados paliativos la atención de la salud bucal en Uruguay teniendo como enfoques referenciales teóricos ~~de~~ la Bioética Latinoamericana. **Metodología**: Revisión narrativa. **Conclusiones:** Se resalta la necesidad de ampliar la agenda de investigaciones interdisciplinarias en esta intersección emergente, investigando las percepciones de profesionales y pacientes, para fundamentar pautas éticas que garanticen sus derechos y una atención odontológica integral, considerando las diferentes dimensiones de la vulnerabilidad.

Palabras clave: Cuidados Paliativos. Cuidados paliativos bucales. Bioética. Vulnerabilidad.

Resumo

Os pacientes em cuidados paliativos enfrentam múltiplas dimensões de vulnerabilidade (biológica, social, moral e programática) que impactam em seu bem-estar e geram diferentes conflitos bioéticos. Apesar da prevalência de problemas bucais entre esses pacientes, a odontologia raramente é integrada em sua atenção paliativa. Objetivo: Examinar as diferentes formas de vulnerabilidade e como são abordadas nos cuidados paliativos em relação à saúde bucal no Uruguai, tendo como referenciais teóricos a Bioética Latino-Americana. Metodologia: Revisão narrativa. Conclusões: Destaca-se a necessidade de ampliar a agenda de pesquisas interdisciplinares nesta interseção emergente, investigando as percepções de profissionais e pacientes, para fundamentar diretrizes éticas que garantam seus direitos e uma atenção odontológica integral, considerando as diferentes dimensões da vulnerabilidade.

Palavras-chave: Cuidados Paliativos. Cuidados paliativos bucais. Bioética. Vulnerabilidade.

Introduction

Palliative care, defined by the World Health Organization (WHO) as an approach to improve the quality of life of patients with life-threatening illnesses, has been explored from various perspectives. The WHO emphasizes the importance of preventing and alleviating suffering through the early identification and treatment of physical, psychosocial, and spiritual problems (1).

The European Association for Palliative Care highlights total and active care for patients whose illnesses do not respond to curative treatments, adopting a holistic approach that encompasses physical, psychosocial, and spiritual aspects (2). The International Association for Hospice & Palliative Care has an active and holistic view of care for people with suffering related to serious illness, aiming to improve the quality of life of patients, families, and caregivers (3).

At the core of palliative care lies a paradigm shift, centered on providing quality of life through support and relief for patients and their families throughout the process, without seeking complete restoration of health (4). Various chronic illnesses, such as cardiovascular diseases, cancer, and respiratory diseases, may require palliative care at some point, significantly affecting patients' daily lives (1). In this context, the recognition of oral conditions is crucial, as they can cause uncomfortable symptoms such as dry mouth, candidiasis, swallowing disorders, dysgeusia, speech difficulties, and specific orofacial pain, some induced by the two most prevalent oral diseases, cavities and periodontal diseases, thus negatively impacting quality of life (4).

Oral symptoms are among the most common issues encountered by patients in palliative care (5-7). These symptoms range from active dental cavities affecting 20% to 33% of individuals (8) to conditions like candidiasis and dry mouth (9). Authors such as Lee et al. (10) and Wiseman (11) have noted that oral complications significantly impact the quality of life of palliative care patients. Thus, oral health needs should be considered in the design of palliative care plans (12,13).

Aligned with the objectives of palliative medicine, palliative oral care aims to preserve quality of life by maintaining oral functionality, state and thus comfort, addressing both physical and psychological needs of patients and their families, and emphasizing early diagnosis of oral conditions to minimize pain and suffering (4,11).

Considering the importance of oral care in the context of palliative care, it is common for oral health teams to be excluded from the holistic, multidisciplinary approach. Yet, up to 89% of palliative care patients experience at least one oral symptom (4), revealing a situation fraught with potential bioethical conflicts.

From a bioethical perspective, individuals receiving palliative care are in a particularly vulnerable position due to the advanced and progressive nature of their illnesses, as well as the treatments they undergo. This vulnerability manifests across various dimensions: physical, psychological, social, moral, and spiritual (14).

Bioethics is an interdisciplinary field that provides theoretical and normative frameworks for analyzing ethical conflicts in healthcare, including those encountered in dentistry and palliative care. Drawing on Latin American bioethical trends, this study distinguishes between the concepts of vulnerable and affected (15-17). The former implies potential for harm, while the latter indicates that harm has occurred. Vulnerability can manifest in several dimensions: biological(18), social(19), moral(19), and programmatic (20,21), among others.

Based on bioethical references, the objective of this study is to analyze various dimensions of vulnerability in the scientific literature addressing oral palliative care.

Methodology

A narrative literature review was conducted to analyze the intersection of bioethics, dentistry, and palliative care through the lens of various dimensions of vulnerability, adopting a personal critical approach to encourage future research.

As noted by Zillmer and Diaz-Medina, a narrative review allows for the incorporation of diverse information from multiple sources, facilitating a comprehensive understanding of a complex subject. While this type of review is not a structured method with criteria for data selection and retrieval, thus making data replication unfeasible, it nonetheless provides a theoretical groundwork for an emerging field and allows to identify pertinent references, methods, and techniques for subsequent research (22).

To this end, a search that encompassed databases such as Bireme (BVS), Scielo, and PubMed was carried out during August 2023, utilizing keywords such as “bioethics,” “dentistry,” and “palliative care.” Priority was given to works centered on Latin American bioethics due to their contextual relevance. Source selection and information interpretation were undertaken reflectively, aiming to underpin discussions linking dentistry, palliative care, and bioethics in addressing the needs of vulnerable patients.

The following selection criteria were employed: a) articles published between 2013 and 2023, articles or texts deemed relevant or pivotal for establishing key definitions in the discipline were also included as references, b) language was limited to Spanish, Portuguese, or English, c) articles containing the words "bioethics," "palliative care," and "dentistry" in the title or abstract, and d) various publication categories were included.

Results

This article presents a comprehensive review of key concepts, perspectives, and theoretical contributions within bioethics, laying the groundwork for subsequent analysis. Historical aspects and the Latin American perspective regarding this field are explored, with particular attention to the diverse dimensions of vulnerability.

The theoretical insights concerning the different dimensions of vulnerability (biological, social, moral, and programmatic) and the moral principles underlying the ethics of care, as delineated in the review, serve as a guiding framework for subsequent discussions. These findings facilitate contextualization and the establishment of connections between the vulnerability experienced by patients in palliative care, the urgent need for dental attention in this context, and the significance of engaging in bioethical reflections that uphold their rights and advocate for comprehensive care.

The review proposes a conceptual framework that cohesively connects the key elements of bioethics, the dimensions of vulnerability, and the care of palliative care patients, emphasizing the importance of advocating for ethical practices that protect the rights of these patients and ensure comprehensive care in the dental setting.

Bioethics - defining the field in Latin America

The field of bioethics has a relatively recent origin, with its evolution beginning simultaneously in two geographically disconnected locations in the United States. The term "bioethics" was coined by the oncologist Van Rensselaer Potter, initially aiming to establish a discipline that would integrate biology with the humanities, focused on ensuring the survival of humanity. Later, he expanded his perspective on bioethics, developing what he called "global bioethics" (23,24).

On the other hand, André Hellegers, in his contribution to the field, prioritized the challenges arising in the relationship between healthcare professionals and patients, as well as the ethical risks posed by technological advancements in the clinical setting. Consequently, he proposed a bioethical perspective centered on clinical aspects, addressing the specific ethical needs of his time (23).

In principlism, bioethics is merely constituted as the application of the four principles to the life sciences field; serving as analytical tools, guiding actions (commonly used in ethics committee deliberations), and directing bioethics education. Their utilization is highly beneficial in terms of respecting individual dignity (25).

A new paradigm for understanding the field of bioethics has been emerging in Latin America, influenced by cultural disparities and inequalities compared to more central countries (24). The UNESCO Declaration on Human Rights and Bioethics provides a distinctly social perspective from a Latin American viewpoint (26). Tealdi proposes a universal ethics grounded in human rights, where dignity, equality, and justice are integrated, contrasting with principled bioethics, expressed as follows:

> "The bioethics of human rights was developed on the basis of two fundamental theses. The first asserts that bioethics, from its inception, represents a diverse field of ethical and normative reflection that allows various modes of thinking, and therefore, diverse bioethics; yet, all rooted in and inseparable from the universal morality of human rights, which includes respect for cultural and linguistic diversity. This thesis serves as a general response to any attempts to disconnect bioethics from the principles

> of human rights. Particularly, as a response to the fundamentalism of ethical principles and moral imperialism (v.) in the neo-pragmatism doctrine linked to neoliberalism. This thesis holds a historical-sociological perspective. The second thesis holds that any theoretical understanding of bioethics must recognize the significance of common sense morality, values, principles, and virtues within the ethical framework of the theory. Additionally, it must underpin the interactions between moral rationality and other forms of rationality, such as legal, scientific, technological, and aesthetic, within the normative domain collectively known as bioethics. It is a philosophical-normative thesis." (27).

Latin American Bioethics is fundamentally characterized by the defense of human dignity, thus justice in access to healthcare must be a priority issue in this region. Since inequity is a factor affecting the dignity of individuals on our continent, the question arises: how to achieve fair access to healthcare and other human rights (27)

Therefore, Bioethics based on respect for human rights is a pluralistic field of ethical-normative reflection that gives rise to different trends that respect sociological, cultural, and linguistic diversity. From its theoretical conception, it underpins moral rationality with other rationalities in a philosophical-normative way.

Finally, we encounter the provisions of the Universal Declaration on Bioethics and Human Rights by UNESCO in 2005 (26). According to Cruz-Coke (2005), this definition is the most comprehensive, well-founded, and extensive declaration in the field of bioethics, enabling a better understanding and dissemination of the defense of human rights worldwide (28).

Latin America faces the challenge of developing a bioethics framework grounded in human rights at the macro level, as opposed to the individualistic micro-level approach prevalent in central countries (29). In light of this perspective, it becomes imperative to analyze vulnerability in its manifold dimensions, given the profound inequalities and exclusions characterizing this context, which place large sectors of the population in vulnerable situations. Examining how vulnerability manifests across various dimensions enables a comprehensive understanding of the factors threatening human dignity and the right to health within the context of dental care in palliative settings.

The intersections of vulnerability

The term "vulnerability" stems from "vulnerabilis," which means "something that causes injury"(15) ;a recently introduced concept into the field of bioethics. Kottow (16,17) and Schramm (30) distinguish between the concepts of vulnerable and affected. The former represents an inherent condition of all living beings, with the potential to be harmed, being fragile, rather than the actual state of being harmed. Safeguarding this vulnerability requires state intervention to equitably shield individuals from harm, thereby preventing their vulnerability from culminating in harm to their integrity (15–17).

In contrast, being affected occurs when damage has already been inflicted, which becomes particularly relevant during decision-making processes (16,17,30). When such damages have already occurred, special care from organized social institutions is required and the establishment of therapeutic and care services to mitigate or rectify the harm is also needed. State intervention is crucial to safeguard the autonomy, integrity, and dignity of those affected (15).

Luisa Neto (2023) proposes a human rights-based approach to vulnerability. She argues that vulnerability is a cross-cutting and universal phenomenon that can impact anyone, irrespective of age, gender, race, ethnicity, or socio-economic status. Neto argues that vulnerability stems from biological, social, economic, or environmental factors, which can be exacerbated by inequality and discrimination. She concludes that human rights offer a legal and ethical framework to protect vulnerable individuals and ensure their dignity and autonomy (31).

Tealdi views vulnerability as follows: "Human vulnerability must be taken into account in the application and advancement of scientific knowledge, medical practices, and associated technologies. Individuals and groups facing specific vulnerabilities must be protected, and the individual integrity of each must be respected" (27).

Not everyone faces the same degree of susceptibility to violations, underscoring the need for tailored protection measures. Especially in peripheral countries, safeguarding against the risks of participation in research becomes crucial, simply because it is more feasible due to illness, weakness, or lower economic conditions (15).

According to Rafael Oviedo, the study of vulnerability emerged in connection with studies on the HIV/AIDS pandemic in the 1990s, where intervention designs were guided by comprehensive care approaches and social mobilization processes based on human rights, marking the introduction of the vulnerability concept into Public Health. In line with the author's premise, the objective of vulnerability is posed as an exploration of how broader social and cultural dynamics, in conjunction with individual factors, create conditions that contribute to the materialization of certain dangers and threats (18).

The term «vulnerability» has been traditionally understood as the potential for harm. In Bioethics, three conceptions of vulnerability are examined: 1) as an inherent and widespread condition of humanity; 2) as a distinctive trait of individuals, and 3) as an international ethical principle rooted in human rights, aiming to uphold human dignity in situations where autonomy and consent are insufficient (32).

In Latin America, various authors offer diverse perspectives on vulnerability. For instance, Garrafa and Prado, as cited by Rocha da Cunha, define vulnerability as pertaining to populations excluded from the benefits of humanity's development, thereby introducing a political and ideological context distinct from earlier considerations (33).

> Garrafa & Prado (2001), for instance, proposed that vulnerability "encompasses various forms of excluding population groups from events or benefits that may unfold in the process of global development." Furthermore, when analyzing the term's application to the ethics field involving research on human subjects, these authors interpreted the adjective *vulnerable* as "the weakest aspect of an issue or problem" or "the point where someone can be attacked, harmed, or injured." This led them to understand vulnerability within a context characterized by "fragility, lack of protection, disadvantage, and even helplessness or abandonment" (Garrafa & Prado 2001:1491).

Dimensions of Vulnerability

Biological Vulnerability

Humans exist within an environment where they constantly interact and strive to survive; adapting, transforming, or vanishing. Discussing biological vulnerability requires considering this dynamic relationship. Therefore, it does not emerge merely as an imbalance or mismatch between the "power" of the living and the "challenge" of the environment, but rather as a specific configuration of the connection between the two (18).

Any situation can lead to a catastrophic event in human life. However, for certain populations with specific biological traits, such as hemophiliacs, this can result in actual harm, which we call biological vulnerability. This trait will influence various aspects of their daily life. The essential vulnerability of living organisms requires a manifestation of intrinsic flexibility, along with the ability to address recursively and, at times, ingeniously the complex circumstances generated by inherent insecurity (18).

In this context, the notions of "recursion" and "ingenuity" emerge as relevant terms, albeit with some caution. Firstly, any response or inventive gesture of the organism unfolds intrinsically within the framework of the possibilities delineated by its normative activity, limiting the possible variants of action. Secondly, these responses are continually influenced by the specific circumstances surrounding the organism, mediated by an inherent "practical attitude or will to action." Conversely, the environment referenced is invariably shaped in relation to the unique condition of the living organism (18). Commonly, illness, old age, disability, etc., are often characterized as vulnerable states. Only when the capacity of the individual declines as a constant factor can we speak of establishing or exacerbating a situation of vulnerability and, consequently, a process of biological, existential, and social weakening (18).

Social Vulnerability

These differences in susceptibility among human beings stem from social or moral conditions, among others. Social vulnerability arises from political and economic structures that have historically generated an unjust system, which routinely channels favors and privileges to certain groups while excluding others from these benefits and privileges. Therefore, it is crucial to consider the circumstances of each group member, particularly their health determinants and how they impact their daily lives (34). This situation becomes an ethical problem, as it is historically perpetuated by the structures that we, as human beings, have created for ourselves, and it can be overcome; it does not solely depend on individuals (19). To overcome these circumstances, intervention bioethics emerges from Latin America (19), particularly in the contexts of peripheral countries where social exclusion, concentration of power, and the adverse effects of globalization prevail (35).

Social vulnerability leads to an environment characterized by fragility, lack of protection, weakness, disadvantage, and even abandonment, as it addresses various forms of social exclusion, ranging from the inaccessibility to the benefits generated by development (35,36).

Undoubtedly, the concept of social vulnerability is pivotal for bioethics, as it allows us to highlight the unjust reality in which people are excluded from social programs and policies solely due to the way human beings are organized (19).

Moral vulnerability

Moral vulnerability is another dimension of vulnerability that needs to be elaborated, since humans can only survive when integrated into society, cultivating bonds, relationships, and cooperative attitudes among individuals for survival. Currently, these interactions occur in a society that values the individual alongside moral pluralism, and our society continues to marginalize social groups that have historically faced discrimination, perpetuating the situation for those who have been morally oppressed throughout history (19). In addition to social differences stemming from various socioeconomic realities, there are groups or individuals who have faced oppression due to other conditions. According to Sanches MA et al.:

> "It encompasses individuals and groups that do not conform to expected morality, leading to negative outcomes such as exclusion, alienation, segregation, and other forms of stigmatization and discrimination. These are often groups that, besides facing explicit social vulnerability, are also morally judged, sometimes subtly and in imperceptible situations that consequently go unnoticed by various protection and intervention bodies" (19).

Moral vulnerability arises from the historical-cultural process that guides the construction of our worldview and our belief systems and value scales. There are some specific forms of fragility that are not related to purely existential or socioeconomic conditions. For this reason, the emphasis is placed on the term 'moral' as an adjective of vulnerability, which implies "that a particular worldview proposes an ethos, and based on it, individuals and groups subscribing to such a perspective may form a 'moral' assessment of behaviors, situations, or individuals not aligned with that standard" (19). From this perspective, vulnerability arises from a deficit in recognizing and respecting others as moral subjects: "morality represents the quintessence of attitudes that we mutually oblige each other to adopt in order to jointly ensure the conditions of our personal integrity" (19).

From the concept of "moral vulnerability," it is possible to interpret the situation of exclusion and discrimination experienced by individuals or groups due to a specific "worldview" or "framework." The formation of this "worldview" involves various aspects, such as cultural, religious, philosophical, and scientific, among others. "Moral" framing is often constructed based on discourses formally presented through theories or ideologies supported by a cultural tradition and frequently backed by a solid philosophical, theological, and scientific foundation. Consequently, individuals or groups deemed "morally fragile" are characterized by arguments stemming from specific cultural traditions, sometimes supported by robust foundations in philosophy, theology, and science. Ultimately, moral vulnerability affects those who do not align with socially predominant practices and customs, resulting in adverse outcomes such as exclusion, alienation, segregation, and various forms of stigmatization and discrimination. These individuals or collectives, besides facing explicit social vulnerability, are often subjected to moral judgments, sometimes subtly or imperceptibly.

Programmatic Vulnerability

This concept is associated with the promotion of health, the right to healthcare services, and the political commitment of governments. It refers to the social and political resources necessary for safeguarding individuals or collectives from risks and ensuring their integrity and well-being in all dimensions. It refers to the quantity and quality of resources, as well as their monitoring in national, regional, or local healthcare assistance programs. These are relevant aspects for identifying existing social needs and resources, and for optimizing their use (20).

It is also associated with aspects such as planning, administration, and response to prevention and treatment needs, among others (21).

It is defined as "the characteristics and processes of institutions that provide various types of services to the population, especially those related to health" (37,38).

Programmatic vulnerability addresses the promotion of programs at the national, regional, or local level in relation to disease prevention and care. It implies the availability of effective and democratic social resources to enable people to prevent diseases and complications. Additionally, it underscores the significance attributed to the issue in the management, planning, monitoring, and evaluation of control actions (20).

Dimensions of vulnerability in oral palliative care

Although people who require palliative care often experience oral health issues, oral health is frequently overlooked, and dentists are rarely integrated into palliative care teams. According to a study by Chen, it was found that 50.8% of 197 long-term care unit residents did not receive oral care in the year preceding their death (39).

While vulnerability is a universal human condition, there are individuals with specific vulnerabilities, which may be exacerbated by personal, socioeconomic, cultural, geopolitical, or environmental factors.

Patients receiving palliative care, as suggested by authors such as Kottow or Schramm, would fall into the category of vulnerable patients, given that the situation of harm has already occurred (17,30). Conducting an analysis from this perspective is crucial for the adoption of policies and programs by institutions, healthcare services, and the state to provide specialized care [15].

Patients in palliative care exhibit additional vulnerabilities due to the fragility of the social protection network, the asymmetry in the care relationship, and the risk of harm they face in healthcare, compounded by moral judgment. Bioethics, by means of Article 8 of the Universal Declaration on Bioethics and Human Rights[26], and human rights, supported by the regulatory framework of human rights in patient care (HRPC), serve as fields of knowledge capable of providing theoretical and normative tools to health policymakers. Through specific reflections and discussions, they can challenge governmental and legislative decisions regarding the vulnerability of palliative care patients, empowering them to be recognized as legitimate rights holders.

Palliative care patients often present a wide array of underlying health issues, such as advanced cancer, chronic heart, or lung diseases. This leads to biological fragility, immunosuppression, and heightened susceptibility to infections. Dental care in this context must be highly tailored. For instance, dental procedures should minimize stress on the patient's immune system and employ techniques that mitigate the risk of infections [40]. Additionally, the administration of effective analgesics and careful consideration of potential drug interactions are crucial to ensure patient comfort and safety.

The social aspect of vulnerability in palliative care patients pertains to factors like family support, financial constraints, and access to healthcare services. Many patients may lack robust support systems and may encounter challenges in affording oral healthcare services. Dental professionals should be sensitive to these social constraints and collaborate closely with social workers and palliative care teams to ensure that patients receive the appropriate care. This might involve referring them to state-funded dental care programs or facilitating access to transportation services for appointments.

The programmatic dimension of vulnerability is tied to the absence of dental care programs specifically tailored for palliative care patients. Often, dental care is not adequately integrated into palliative care plans, resulting in its oversight. To address this vulnerability, it is imperative for palliative care teams to acknowledge the significance of oral care and engage professionals in developing tailored protocols and programs. This could involve regular oral assessments and the integration of preventive and palliative oral care into the patient's comprehensive care plan.

The moral dimension of vulnerability involves ethics and decision-making in the care of palliative care patients. Patients may find themselves in situations of moral vulnerability due to their inability to articulate their preferences for oral treatment. Dental professionals must collaborate closely with palliative care teams and family members to make ethical decisions and honor the patient's values and preferences.

Discussion

In our medicalized society, it is necessary to reconsider how we perceive death, shifting away from viewing it as an adversary to be defeated and embracing a more holistic perspective. The tendency to credit physicians for cures and place blame on patients only serves to perpetuate a confrontational stance against death. It is crucial to question the ethics of medical interventions in this context, recognizing that the mere availability of technologies does not automatically justify their ethical application. Healthcare professionals must prioritize respect for patient privacy, integrity, and identity, critically evaluating the extent to which interventions adhere to these principles. Ultimately, ethics should guide medical decisions, ensuring a balance between technical proficiency and respect for patient autonomy [41].

Palliative care patients are often marginalized by a society that struggles to accept the natural process of human death (42-44); as these patients do not conform to the expected morality, they face negative consequences such as exclusion, alienation, and lack of attention (19).

This culture is strongly embedded among oral health professionals, who may disregard the rights of palliative care patients to treatment because they do not fit the typical profile encountered in dental practice. This can be analyzed from a moral vulnerability standpoint.

Palliative care constitutes a human right and is guaranteed in Uruguay through a series of regulations (45-49). It stands out in Latin America for having the highest percentage of palliative care teams (24.49 per million inhabitants) and for providing assistance to children and adolescents (19.3 per million inhabitants) (50), as provided by Law 18.211 which creates the National Integrated Health System (45). However, oral health is not included within these regulations.

Within this context, elements intrinsic to dignity, morality, culture, and theories supported by a hegemonic group are identified as contributing factors to significant disparities, surpassing the mere influence of economic and social factors on vulnerability (51).

Reflecting these dynamics in the field of oral health in Uruguay, a complex interaction emerges between moral and cultural elements that influence the perceptions and practices of the population. The lack of cultural awareness regarding the importance of oral health care becomes a substantial challenge. As noted by Soares, there are gaps in training concerning the management of oral manifestations in palliative care patients, as well as in research and specific protocols in the field (52). Additionally, Beñaran highlights the predominantly liberal nature of the dental profession (53) in the country, which limits the ability to effectively address all the oral health needs of the population.

Such a scenario, where the complete loss of teeth in the elderly is perceived as normal or acceptable (54), underscores a normalization deeply rooted in morality and reinforced by the dental profession. The failure to acknowledge this situation as preventable reflects the influence of moral and cultural factors ingrained in Uruguayan society.

In this reflection, moral vulnerability emerges as a fundamental, and sometimes underestimated, component shaping disparities in dental care. Addressing these challenges entails not only clinical interventions but also a profound cultural and moral shift that acknowledges the significance of oral health and challenges entrenched practices to promote more equitable and preventive care for the entire population.

The relationship between bioethics and oral palliative care is intricate and multifaceted. On one hand, oral palliative care is subject to the same bioethical considerations as any other form of healthcare. On the other hand, patients in palliative care face specific vulnerabilities that must be considered in bioethical analysis (51,55).

Palliative care patients find themselves in a situation of particular vulnerability. This vulnerability may stem from the underlying illness, the treatment they receive, or their personal, social, and moral circumstances. Therefore, bioethics, following the perspectives of Kottow (16,17) and Schramm (30), should prioritize the protection of vulnerable individuals.

Utilizing vulnerability dimensions in the bioethical analysis of patients receiving palliative care enables the identification of specific aspects of their vulnerability that should be taken into account in decision-making and service provision.

For example, a palliative care patient with a painful oral disease may exhibit physical and psychological vulnerability. In this scenario, the dentist must consider the patient's capacity to tolerate treatment and ensure that it does not exacerbate their pain (22,55).

Another example involves a palliative care patient with an oral disease that hinders their feeding ability. Here, the dentist should take into account the patient's nutritional needs and collaborate with the palliative care team to ensure adequate nutritional support (52,56).

Dental care in palliative care patients is crucial for enhancing their quality of life (11,13), yet these individuals face various dimensions of vulnerability that require specific attention. By addressing the biological, social, programmatic, and moral dimensions of vulnerability, oral health professionals can offer more effective and compassionate care, ensuring comprehensive and ethical fulfillment of their needs. Recognition and management of these dimensions are critical for providing quality dental care in the context of palliative care (57).

Final considerations

In this article, vulnerability was proposed as a cross-cutting element for understanding the relationship between bioethics and oral palliative care. Vulnerability is a multifaceted concept that can be defined in various manners.

Oral health care constitutes a significant component of palliative care, yet it has often been overlooked due to a lack of recognition regarding the importance of including dentists in the care team. Dentistry plays a critical role in both preventing and treating oral diseases in these patients. It is imperative for dental and palliative care professionals to collaborate closely to deliver comprehensive, high-quality care to palliative care patients.

In the context of oral palliative care, the vulnerability of patients must be considered in all aspects of care, from decision-making to service provision.

Bioethics, with its normative philosophical nature, has the potential to contribute to reflection and exert influence through normative references in ethical decision-making, as well as in the consideration of patients' values and rights.

Vulnerability is a fundamental concept for understanding the relationship between bioethics and oral palliative care. The use of vulnerability dimensions in the bioethical analysis of palliative care patients may enable the identification of specific aspects of their vulnerability that should be considered in decision-making and service provision.

While this study has contributed to the discussion on the intersection of dentistry, palliative care, and bioethics, empirical research is necessary to articulate the dimensions of vulnerability in palliative care patients from both the patients' own perspectives and those of the professionals working with them. Additionally, such research should propose guidelines to promote this integration and guide dental practice in palliative care within the healthcare system, taking into account the rights and specificities of these patients.

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Conflict of Interest Statement

The authors of this work declare that they have no conflicts of interest.

Source of Funding

This project did not receive funding from external sources.

Authorship Contribution Declaration

a) Study conception
b) Data acquisition
c) Data analysis
d) Results discussion
e) Manuscript drafting and editing
f) Approval of the final version of the manuscript

RDS has contributed to: a, b, c, d, e, and f.
TRDA has contributed to: a, d, e, and f.
SB has contributed to: a, d, and f.

Acceptance note

This article was approved by the journal editor PhD. Dr. Vanesa Pereira-Prado.