Important Notice

This is one of a series of ethical dilemmas published in the *Texas Dental Journal* between 1993 and 2005. The lead author of these dilemmas, Dr. Thomas K. Hasegawa, died tragically in 2005. The dilemmas remain an important legacy for dentistry.

Format

Each ethical dilemma was originally introduced in one issue of the *Texas Dental Journal* with the question, “What would you do?” The more expansive analysis of the dilemma was presented in a subsequent issue. The second page of this file depicts the cover of the issue containing the analysis of the dilemma, not the issue containing the briefer introduction to the dilemma. The ethical dilemmas were compiled for digital use by the American College of Dentists in 2008.

Purpose

This ethical dilemma and the other dilemmas in the series are only meant to further your knowledge and understanding of dental ethics by presenting, discussing, and analyzing hypothetical ethical dilemmas that may occur in dental settings. The dilemmas are not intended to: a) provide legal advice; b) provide advice or assistance in the diagnosis or treatment of dental diseases or conditions; or c) provide advice or assistance in the management of dental patients, practices, or personnel.

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Support

For more information about this series of digital ethical dilemmas, contact:

American College of Dentists
839J Quince Orchard Boulevard
Gaithersburg, MD 20878-1614

301-977-3223
fax 301-977-3330
office@acd.org

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patients. Specialists also serve as expert witnesses to evaluate competency and establish standards of care in dental litigation cases. They may be privy to instances of gross or faulty treatment in their private referral patients and may experience role conflicts between not harming either their patients or the referring dentists.

The ADA Code of Ethics offers guidelines for consultation and referrals that include returning the patient to the referring dentist after the specialty is completed. In cases of a consultation for a second opinion, the Code also specifically states that “the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.” (1) It is unclear whether Dr. Biggs has asked Dr. Wilkins to treat Mr. Crane or offer a second opinion.

Mr. Crane has asked the periodontist, “Are these crowns causing a problem for my gums?” Since the crowns were provided by the referring dentist, how should the specialist respond to the patient? The periodontist is a new practitioner in an established specialty practice, and revealing unfavorable information to the patient may be poorly received by both Mr. Crane and Dr. Biggs. Specialists as well as generalists prosper by building and nurturing their referral network, although in this case, communication is scant between Drs. Wilkins and Biggs. Should Dr. Wilkins answer Mr. Crane’s question?

Conflict, Collusion, or Collaboration?

Most dentists chose to inform Mr. Crane that some of his crowns need replacement, risking conflict among the generalist, specialist and patient. A periodontist wrote that either the crowns should be replaced or, if the crown margins were not open, apical positioning of the soft tissue next to the crowns be performed. “The responsibility is to the patient first,” wrote another dentist.

The case could also be managed through collusion, defined as a “secret agreement between two or more persons for a deceitful or fraudulent purpose.” (2) It is possible that a generalist and specialist could agree to

What Would You Do?

Ethical Dilemma #14

Charles Finley is a 45-year-old construction worker whom you have seen on a sporadic basis over the last four years. You have practiced general dentistry in the same location now for ten years in a community of 2,000 and the nearest regional medical center is 150 miles away. Mr. Finley was recently diagnosed with a head and neck malignancy and received radiation treatment of 6000 cGy that included his mandible. His chief complaint is multiple painful teeth.

Visual examination reveals multiple decayed teeth, four that probably involve the pulp and one that may need to be extracted. Although he has not been a regular patient during the last three years, he has kept his appointments and paid his bills.

Mr. Finley is worried because he was told that because of his radiation treatment, he was at high risk for osteoradionecrosis from dental infection or extractions. He does not have dental insurance and admits that he has limited funds. He pleads with you — “Please help me, you are my only hope for treatment!”

You are now faced with an ethical dilemma. Check the course of action that you would follow and mail or fax this page, or a note indicating your recommendation, as instructed below:

1. _____ prescribe antibiotics and dismiss the patient,
2. _____ treat the infected teeth with root canal therapy,
3. _____ dismiss the patient,
4. _____ treat all the teeth comprehensively,
5. _____ treat symptomatic teeth with extractions, having Mr. Finley acknowledge the risks, or
6. _____ other alternative (please explain).

SEND YOUR RESPONSE BY NOVEMBER 5, 1994 ATTENTION:
Dr. Thomas K. Hasegawa, Jr., Department of General Dentistry, Baylor College of Dentistry
P.O. Box 660677, Dallas, TX 75266-0677
or FAX to (214) 828-8952.
Response to Ethical Dilemma #14

Charles Finley is a 45-year-old construction worker who (see complete case in the October, 1994 issue) you have seen on a sporadic basis over the last four years. You have practiced general dentistry in the same location now for 10 years in a community of 2,000 and the nearest regional medical center is 150 miles away. Mr. Finley was recently diagnosed with a head and neck malignancy and received radiation treatment of 6000 cGy that included his mandible. His chief complaint is multiple painful teeth.

Visual examination reveals multiple decayed teeth, four that probably involve the pulp and one that may need to be extracted. Although he has not been a regular patient during the last three years, he has kept his appointments and paid his bills.

Mr. Finley is worried because he was told that because of his radiation treatment, he was at high risk for osteoradionecrosis (ORN) from dental infection or extractions. He does not have dental insurance and admits that he has limited funds. He pleads with you—"please help me, you are my only hope for treatment!"

The dentists responding to this case chose either to treat the infected teeth with root canal therapy (option #2), or treat all the teeth comprehensively (option #4). None chose to prescribe antibiotics and dismiss the patient (option #1), dismiss the patient (option #3), or to treat all symptomatic teeth with extractions, having Mr. Finley acknowledge the risks (option #5). Alternatives were noted by letter and note and will be included in the response.

Proper treatment for a patient requiring head and neck radiation treatment (RT) includes a thorough dental exam and comprehensive case planning which should be coordinated with the radiation oncologist prior to RT. In this case, however, the dentist is not included by the radiation oncologist, and so must deal with the patient as presented.

There are three ethical issues involved: 1) the role of the dentist in preventing even further harm to the patient; 2) trust in the doctor-patient relationship; and 3) the responsibility of the profession to educate other health professionals about the complications associated with oral disease.

Preventing Further Harm

Preventing harm is a primary goal and attribute of our profession, but there are instances where harm has already occurred and the dentist’s concern is preventing further harm to the patient.

Mr. Finley received head and neck RT without the benefit of prior consultation and coordination of dental care between the dentist and the radiation oncologist, although the patient was informed that he was at high risk for ORN from dental infection or extractions. Now Mr. Finley comes to you with multiple painful teeth, pulpal involvement and the possibility of one tooth needing extraction. These are conditions that should have been treated prior to RT.

The first step in preventing further harm to the patient is to initiate a comprehensive review of his case with the radiation oncologist to identify the type of malignancy, and to locate the precise site including the point of entry, volume of tissue exposed, type of radiation used and the dosage, for determining the tissues at risk. Now you can begin a dialogue to coordinate dental care with a knowledge of his RT history that relates to the treatment plan of the radiation oncologist. There are a number of side effects following RT that may require the dentist’s expertise, including the difficulty in eating caused by xerostomia, mucositis, dysphagia, ageusia, nausea and vomiting, and loss of appetite along with the potential for radiation caries, trismus, pain and ORN. (1)

The next step is to establish a comprehensive dental treatment plan for Mr. Finley that includes root canal and restorative therapy for the painful teeth in conjunction with a meticulous periodontal evaluation, treatment, and maintenance program. Artificial saliva may be prescribed to manage xerostomia that may be present along with analgiesics for his pain, and antibiotics and/or antifungal medications. Removable, rather than fixed, prosthodontics is indicated if he has a high caries activity, and there may be an indication for endodontics, followed by crown amputation rather than extraction. Frequent dental recalls must be part of the comprehensive plan, along with the use of fluoride carriers to prevent radiation caries.

Invasive surgical procedures exposing bone at the RT site is contraindicated because the bone is hypoxic, hypocellular and hypovascular making it prone to ORN. (2,3) ORN is regarded as a condition of previously radiated bone which compromises its ability to remodel, re
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pair and subsequently combat infection. An invasive surgical procedure may cause ORN because the bone is subject to tissue breakdown that may result in a non-healing wound. Osteoradionecrosis is a problem of wound healing rather than infection, (3) and if the extraction is necessary for Mr. Finley, precautions to minimize the risk includes: 1) prophylactic antibiotic therapy; 2) achieving primary closure of the surgical site and eliminating sharp ridges; and 3) the possible use of hyperbaric oxygen therapy (HBO) before and after the surgery.

Although proper preventive dental treatment will not eliminate the possibility of ORN, the failure to follow these recommendations may result in an adverse result for the patient and a lawsuit for the dentist. ORN may be a severely debilitating condition resulting in skeletal deformity. The ADA News this year reported a $2.96 million settlement made by a Florida jury to a dental patient who developed ORN after dental extractions. The lawsuit charged the defendants with “negligent failure to consult with or refer to an oral surgeon, negligent dental extraction, negligent supervision of surgical site and negligent failure to obtain informed consent for the extraction.” (6)

To practice competently, dentists must continue to improve the care they deliver through education, training and research, and to keep their knowledge and skills current. (7)

It is equally important that all health professionals, including radiation oncologists, keep their knowledge and skills current. What is the importance of the doctor-patient relationship in this case, especially when the dentist was not involved in proper preventive dental therapy before RT?

What Would You Do?
Ethical Dilemma #16

Carole Walker is a 35-year-old high school English teacher and is a new patient in your general practice in a large metropolitan city in Texas. She is in good general and oral health and her previous care consisted of small amalgam and resin restorations. She has come to your office because another teacher has recommended you, even though she must drive 45 minutes to your office. You have been in practice now for four years and enjoy the location and the growth of your practice.

One of her concerns is sensitivity to cold and when she brushes her teeth in the upper right canine area. She has a cervical abrasion into dentin on the facial surface of tooth #6. She has a clinically sound disto-lingual amalgam on #6 that was placed several years ago. The treatment plan is for Class V resin and you isolate, prepare, etch, place and polish the restoration. She is pleased with the appearance of the restoration and with the appointment.

That evening she calls you and she is in acute pain that started three hours after the appointment and has been “throbbing” for the last two hours. She is angry and disappointed and asks, "Why didn’t you tell me this could happen?" You prescribe analgesics and see her the next day and determine that she has an irreversible pulpitis that will require root canal therapy. You try to explain to her that this dramatic response to the placement of small resin restorations rarely happens, but she is now upset because she has heard "horror stories" about root canals and she asks, "Why should I pay the extra expense if I wasn’t informed about the possibility of this happening?"

You are now faced with an ethical dilemma. Check the course(s) of action that you would follow and mail or fax this page, or a note indicating your recommendation, as instructed below.

1. Refer her to an endodontist for evaluation and treatment at her expense.
2. Refer her to an endodontist for evaluation and treatment at your expense.
3. Proceed with the root canal at her expense.
4. Proceed with the root canal at your expense.
5. If she continues to be upset, discontinue her as a patient.
6. Other alternative (please explain)

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Dr. Thomas K. Hasegawa, Jr., Department of General Dentistry, Baylor College of Dentistry
P.O. Box 660677, Dallas, TX 75266-0677
or FAX to (214) 828-8952.

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between the patient and his physician. Mr. Finley must deal with the diagnosis of a malignancy and the fear of ORN, and he trusts that his health professionals are the experts who have the knowledge and skills to “cure” him. The imbalance of this relationship has caused some to criticize doctors of being paternalistic, or treating the patient as you would a child, which has a long history in medicine and dentistry. The philosopher Edmund Pellegrino has described the “ethic of trust” as the cement of this imbalanced, doctor-patient relationship and that, “both are locked in a human relationship the acuteness of which is rarely encountered in day-to-day life.” (8)

The TDA’s Principles of Ethics describes the relationship as “Trust by the public that serving their true dental needs with appropriate quality care is the heart of the patient-dentist relationship. This concept of trust, imbued with dedicated service, is the hallmark of professionalism…” (9)

A dentist who decides to treat Mr. Finley will be locked in a relationship that may require the full measure of that dentist’s knowledge, skill and commitment throughout treatment. In this case, dentists chose to: 1) treat the infected teeth with root canal therapy; 2) treat him comprehensively; or to 3) try and refer him to a dental site that can treat him comprehensively. In response to the patient’s limited funds and no dental insurance, one respondent wrote: “I have practiced in a town of 2,000, and people will let you do as much free dentistry as you can stand. I will give him a discount if he does it all at once, but no free work. I’m sorry, but I can’t be charity to everyone.”

Patients assume that the doctor has the knowledge and skills to practice competently and that lifelong learning is a core commitment of that professional role. A dentist wrote that the physician treating Mr. Finley “should have anticipated the dental problems and had his dental problems and dental needs evaluated prior to radiation.” Does the dentist have an obligation to confer with Mr. Finley’s radiation oncologist about the need for proper oral therapies and RT?

Educating Health Professionals

Preventing complications due to RT is knowledge that is not restricted to our profession but an important component of the practice of medicine. This case illustrates the impact of proper dental therapy on the lives of our patients.

If the benefit of our patients is our primary goal, (7) it is the obligation of the dentist to contact the radiation oncologist and address these concerns for proper dental therapy before, during, and after RT to manage the numerous side effects and to minimize the risk of ORN.

Several steps could have been taken to coordinate Mr. Finley’s dental care prior to RT including: 1) coordinate therapy with radiation oncologist, regarding RT site, dosage and timing; 2) complete restorative and periodontal treatment; 3) extract teeth that would be compromised by RT (caries, severe periapical or periodontal disease; 10), or abutting or invaded by neoplasm—remove bony ridges; 4) allow proper healing time of two to three weeks prior to RT; and 5) institute preventive measures including routine oral prophylaxis and fluoride treatments. (1,2)

Conclusion

Dentists are committed to preventing harm to their patients and, in some cases, preventing further harm by educating other health professionals about the consequences of dental disease. Patients who receive RT for head and neck malignancies must be seen for a comprehensive dental evaluation and coordination of dental care with the radiation oncologist to prevent complications and to prepare the patient properly for the many complications associated with RT.

The dentist can lower risks of debilitating conditions like ORN by coordinating proper dental treatment before, during, and after RT with the radiation oncologist. Is Mr. Finley my patient? Most respondents said “yes.”

References

1. Haveman CW. Radiation therapy for head and neck cancer: Oral complications. Oral disease update 1994;1(1):2-6. (This is a publication of the TDA’s Dental Oncology Education Program and is available by contacting the TDA at (800) 460-8700.

EDITOR’S COMMENT: Responses to the ethical dilemmas are views of the contributors and consultants and not Baylor College of Dentistry, the National Center for Policy Analysis or the Texas Dental Association. Address your comments to Dr. Thomas K. Hasegawa, Jr., Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677, or fax to (214) 828-8952. Neil Frederiksen is the Director of Radiology, Department of Diagnostic Sciences, Baylor College of Dentistry.

EDITOR’S NOTE: I would like to thank the dentist who submitted Case #14. The authors remain anonymous to protect the confidentiality of all those associated with the case. If you have an “impossible case,” or one that has been a particular concern for you, please consider calling or sending the case to my address.