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:

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that has the knowledge and skills to assess competence. Providing quality care in a competent manner (2) is a central value for the dental profession (3) and a common value of the health professions. The ADA Code of Ethics was revised in 1993 to include section 1-N (Chemical Dependency) that states:

"It is unethical for a dentist to practice while abusing controlled substances, alcohol or other chemical agents which impair the ability to practice. All dentists have an ethical obligation to urge impaired colleagues to seek treatment. Dentists with first-hand knowledge that a colleague is practicing dentistry when so impaired have an ethical responsibility to report such evidence to the professional assistance committee of a dental society. (2)"

Although the ADA Principles of Ethics does not address dental auxiliaries, patients also expect that their doctors will prevent harm by impaired dental auxiliaries. In this regard, the obligation to prevent harm by chemically-dependent practitioners may be extended to include dental auxiliaries.

Second, dentists recognized the ethical dilemma between confronting Sarah and protecting patients as one of conflicting loyalties, since she has been a long time employee who has become an integral member of the practice. One respondent said that she should "warrant extra consideration" and that her welfare should also be a concern. Dentists may feel an obligation to help their employees when they are faced with personal problems that affect their work. They may also feel an obligation to confront an employee as in Sarah's case because she is a friend who needs help.

The ethical dilemma then is that one cannot chose to ignore Sarah’s suspected impairment without the possibility of exposing patients to harm. What are some alternatives to

<table>
<thead>
<tr>
<th>What Would You Do?</th>
<th>Ethical Dilemma #15</th>
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<tbody>
<tr>
<td>Carol Stallings is a healthy 45-year-old who has been in your general practice for 15 years and who has had regular dental care. She was a fearful dental patient who had poor experiences as a child and over the years you have managed to help Carol manage her fears. She trusts you implicitly. You have seen her regularly over the last few months to try to identify the source of pain that started as diffuse occasional pain in the upper right quadrant. Her third molar was extracted 10 years ago and she has small, clinically sound MOD amalgam restorations on all upper right posterior teeth. Although there was some wear on cusp inclines, she reports that she does not brux. You have studied radiographs, transilluminated all of her teeth, percussed the cusps at different angles, probed the occlusal fissures with a sharp explorer, and had the patient bite to try to identify the source of her pain. On the first appointment you adjusted the small interferences. When that wasn't successful, you removed the small MOD restorations, checked for cracks and replaced them with IRM. Heat, cold, and electrical pulp tests again were inconclusive in the quadrant. Carol does not have allergies and her sinuses have a normal degree of radiolucency on both sides. Carol was unable to reach you last weekend for an emergency and was seen by the dentist of a friend. The dentist diagnosed that she had fractured teeth and recommended the extraction of the upper right first and second molars. She refused this treatment and the dentist prescribed an analgesic and returned her to your office. Carol is now insisting, &quot;we need to do something, please extract the teeth, I trust you and I don't want anyone else to extract them.&quot; You explain that you do not agree with the treatment but she continues to insist &quot;we need to do something!&quot; You are now faced with an ethical dilemma. Check the course of action that the dentist should follow and mail or fax this page, or a note indicating your recommendation, as indicated below.</td>
<td></td>
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<tr>
<td>1. _______ extract the upper right first and second molars</td>
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<tr>
<td>2. _______ recommend and proceed with root canals on the upper right first and second molars</td>
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<td>3. _______ refer her to a neurologist for further evaluation</td>
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<tr>
<td>4. _______ prepare the upper right first and second molars for crowns, cement temporary crowns, and wait to see if this improves her symptoms</td>
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<td>5. _______ other alternative (please explain)</td>
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SEND YOUR RESPONSE BY **DECEMBER 6, 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.
The Painful Diagnostic Dilemma

Response to Ethical Dilemma #15

Carol Stallings (complete case in November TDA Journal) is a healthy 45-year-old who has been in your general practice for 15 years and who had regular dental care. She was a fearful dental patient who had poor experiences as a child and over the years you have helped Carol manage her fears. She trusts you implicitly.

You have seen her regularly over the last few months to try to identify the source of pain that started as diffuse occasional pain in the upper right quadrant. Her third molar was extracted ten years ago and she has small, clinically sound MOD amalgam restorations on all upper-right posterior teeth. Although there was some wear on cusp inclines, she reports that she does not brux. You have studied radiographs, transilluminated all of her teeth, percussed the cusps at different angles, probed the occlusal fissures with a sharp explorer, and had the patient bite to try to identify the source of her pain. On the first appointment, you adjusted the small interferences. When that wasn't successful, you removed the small MOD restorations, checked for cracks and replaced them with IRM. Heat, cold, and electrical pulp tests again were inconclusive in the quadrant. Carol does not have allergies and her sinuses have a normal degree of radiolucency on both sides.

Carol was unable to reach you last weekend for an emergency and was seen by the dentist of a friend. The dentist diagnosed that she had fractured teeth and recommended the extraction of the upper right first and second molars. She refused this treatment and the dentist prescribed an analgesic and returned her to your office.

Carol is now insisting, "we need to do something, please extract the teeth, I trust you and I don't want anyone else to extract them." You explain that you do not agree with the treatment but she continues to insist "We need to do something!"

The relief of pain is a core obligation of health professionals but occasionally the subjective nature of the patient's symptoms makes the diagnosis perplexing. Carol's case caused our respondents to abandon the four original options and write their own. The original options were: 1) extract the upper-right first and second molars; 2) recommend and proceed with root canals on the upper-right first and second molars; 3) refer her to a neurologist for further evaluation; and 4) prepare the upper-right first and second molars for crowns, cement temporary crowns, and wait to see if this improves her symptoms.

Carol's case illustrates how the attempt to relieve pain, while not harming the patient, is a dilemma when the diagnosis is unclear. Respondents' managed Carol's painful diagnosis with varied diagnostic and treatment regimens.

Relief of Pain / Do No Harm

Patients seek the doctors' skills to relieve pain while avoiding unnecessary harm. Since treatment choices have benefits and harms, the incorrect diagnosis of the etiology of the pain, whether it is dental pain as in Carol's case, medical pain such as a back spasm, or the intractable pain of the terminally ill patient. A patient's pain is often at the hub of the moral controversies about qualities of life issues, a patient's right to die, passive and active euthanasia, and physician-assisted dying. Painful dental experiences were exploited in movies like the "Little Shop of Horrors" and "Marathon Man," where the instruments used to heal the patient were used savagely and sadistically. The
Relief of dental pain is a skill that patients expect and our dental Code of Ethics defines. The TDA Code states, “Professional competence is the just expectation of each patient,” (1) and the ADA Code adds, “the overriding obligation of the dentist will always remain the duty to provide quality care in a competent and timely manner.” (2)

The desire not to harm Carol was clear in this case, as NONE of the respondents chose to follow Carol’s wishes and extract her molars. In an attempt to alleviate her pain, dentists chose to either treat her symptoms as a cracked tooth or as a temporoman-dibular disorder (TMD).

One-half of the respondents attributed Carol’s pain to a cracked or fractured tooth, but were divided in treatment alternatives. Some chose selective local anesthesia techniques such as “PDL,” or “posterior or middle superior injections” to attempt to localize the offending tooth. Others chose to reduce the occlusion with or without placing orthodontic bands, or to refer the patient to an endodontist for a second opinion. Her symptoms did not fit the “classic” cracked tooth syndrome (3), as she was neither sensitive to thermal tests nor reported pain on mastication. However, cracked teeth may have a vital response to pulp tests, no pain on vertical percussion, and may be difficult to localize the pain to one tooth. (4) She did have MOD restorations which makes the teeth more prone to fracture, although the amalgams were small in size. (5) She did not have any signs of bruxism (4) or notable history from 15 years in the practice. All of these elements factored into the difficult nature of the case. One clinician, an endodontist, noted that some key information was missing, such as the nature of the pain, the patient’s response to palpation of “associated muscles and alveolar bone over the teeth,” or if there was any history of trauma in this area. Even after a full coverage restoration, some patients will still have symptoms and will need endodontic treatment. (4)

What Would You Do?

Ethical Dilemma #17

Alan Norris is a 35-year-old advertising salesman for a local company who came to your general practice because a co-worker said that you were “painless” and used “laughing gas.”

You first saw Alan three months ago as an emergency patient with a pericoronitis associated with a partially erupted mandibular third molar. His medical history and vital signs were unremarkable, and his dental history included several painful experiences as a child which made him “afraid of the dentist.” He also admits to using recreational drugs, especially marijuana, in college, although he “didn’t inhale.” All of his dentists used the “gas,” and he added, “this is the only way I can tolerate dental drilling.”

You used nitrous oxide oxygen sedation during the surgical extraction and his restorative appointments. This is his third appointment, and you are concerned that his need for “gas” was more for pleasure than the avoidance of pain. He inhales deeply during the appointments and asks you to “crank it up.” He even told your assistant in confidence, “this gas is great, it really gives me a high.”

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. _____ Continue to treat Mr. Norris using nitrous oxide oxygen sedation.
2. _____ Continue to treat Mr. Norris using nitrous sedation but lower the dosage during the appointment.
3. _____ Discuss your concerns with Mr. Norris and attempt to determine if he is a substance abuser. If he denies being an abuser, proceed with #1 or #2.
4. _____ Discuss your concerns with Mr. Norris, and if he admits to being an abuser, insist that he have professional counseling before you resume treatment using nitrous sedation.
5. _____ Discontinue treating Mr. Norris.
6. _____ Other alternative (please explain)

Send your response by February 4, 1995 attention:
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The remaining one-half of the dentists chose to perform a “TMJ” or “myofascial pain” examination. This included palpating the muscles in the head, neck, and shoulders and feeling for “triggerpoints,” followed by the fabrication of a “TMJ” or “bite” splint. The complexity of this diagnosis is portrayed by the variety of names such as TMD (6), TMJ, MPDS (myofascial pain dysfunction syndrome) (7), and CMD (craniofacial dysfunction) (8). ElliotRam, a private practitioner, wrote that, “many practitioners believe (TMJ disorder) has become a ‘wastebasket’ diagnosis of anyone presenting with a headache or pain of unknown origin.” (8) Some dentists wrote that if the “TMJ” or “myofascial” treatment failed in Carol’s case, they would choose either to treat the molars with root canals or prepare the molars for crowns and cement temporary crowns.

Patterns of Practice

The competent and effective clinician develops through education, training and experience, the expertise to deal with the myriad of cases, like Carol’s. Clinicians, as in Carol’s case, don’t always agree, however, and we can see in this case how a clinician’s philosophy or, what philosopher David Ozar calls, “pattern of practice,” (9) affects decision making.

The dentist makes a host of decisions in daily practice that range from the practical questions of what dental chair to buy to the complex diagnosis and treatment strategies for cases like Carol’s. Much of the knowledge and skill of the clinician is learned over time, and David Ozar describes the process this way: “No one can effectively apply complex expertise to concrete situations, such as the specific clinical needs of a particular patient, if every detail of that application must be self-consciously judged and chosen each time it arises. For this reason, becoming a competent and effective professional is, in significant measure, becoming capable of applying many aspects of one’s expertise habitually, without self-conscious attention.” (9) Just as the clinicians were split between a cracked tooth or TMD diagnosis, competent clinicians may disagree on the prosthetic replacement of missing teeth, or if healthy or restorable teeth should be extracted. The dentist’s pattern of practice may change with education, training and experience, as one dentist noted, “thirty-eight years in dentistry and ‘still learning’ and helping others.”

Conclusion

Carol’s painful dilemma reminded us that competent, compassionate clinicians may disagree on the diagnosis and treatment of painful conditions, and that dentists are occasionally faced with situations where a definitive diagnosis is not possible. Dentists that wrote about Carol’s case shared a common concern for the relief of pain, accurate diagnosis and conservative therapy, but responded differently when they were faced with her insistence that “We do something.”

References


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. Dr. John W. Harrison, an endodontist, is a Professor in the Department of Restorative Sciences, Baylor College of Dentistry. ★