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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You Make The Difference
they are supposed to serve," and, "The special shame of capitation is that a concept, where feasibility was demonstrated, has, with few exceptions, been perverted (1)."

Cost containment is a primary goal of current dental programs. The yearly capitation rate in Schoen's 1954 program was $60 per year per child (2), a figure that was "low but competitive with fee-for-service options (1)." By 1993 standards, that yearly amount is equivalent to $332, or about $28 ppm (2). A profile of four independent practice network plans examined capitation reimbursement, and it was estimated that a capitation reimbursement of $6.94 ppm (comparable to Dr. Foster's $6.00 ppm plan) would cover 35 percent of the average cost of providing care for patients. At overhead costs over 50%, this would neither meet the overhead nor begin to compensate the dentist (1, 2). Schoen observed "the incentives to undertreat and to cut corners are enormous (1)." The philosopher David Ozar describes this as a "terrible ethical bind" that places pressure on a dentist to consider providing inadequate treatment for patients (3).

Dr. Foster's capitation plan has high benefits (100 percent of crowns with no copayments) with low premiums and a high utilization rate. Will his practice survive? Will patients

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**What Would You Do?**

**Ethical Dilemma #24**

Ashley Jacobs is a new patient in your general practice who has recently moved with her family from Seattle. Her father is in the oil and gas business and the family has moved six times in the last four years. She is 16 years old and her mother reports that she is in good health. Her vital signs are within normal limits and she has had the usual childhood diseases.

Your first impression is that she looks very thin at 5'4" and 105 pounds. She has received yearly dental examinations, and her mother notes that she has had few fillings although her teeth have been more sensitive to cold these last three years. Ashley stopped eating ice cream and drinking cold drinks about the same time, and her mother notes that her weight is about the same since then.

Ashley has a quiet, pleasant demeanor and answers questions with a yes or no. As you begin your examination she immediately asks, "please don't use water or air on my teeth." Her previous dentists, she explained, avoided using cold water or air. The oral examination reveals mild to moderate enamel loss due to acid erosion on the lingual surfaces of the maxillary centrals and laterals.

As you ask if she ever has any problem with "sour stomach" or vomiting, she becomes very nervous and upset. "How do you know that?" she asks, and says "maybe I have an occasional problem with vomiting." You explain that acid from vomiting causes erosion of the enamel and that chronic vomiting may be a serious health problem. Ashley breaks down and admits that she frequently self-induces vomiting. She and a few friends have the "same problem." She pleads, "please don't tell my mother, she'll just freak out! I'm better now and my mom doesn't need to know."

You are faced with an ethical dilemma. Check the following course(s) of action you would take here and mail or FAX this page, or a note suggesting your recommendation, as instructed below:

1. _____follow Ashley's recommendation and avoid telling her mother;
2. _____ask Ashley to tell her mother or you will;
3. _____inform Ashley that you will inform her mother, as you are concerned for her health;
4. _____inform Ashley that she may need professional help and that not telling her parents may contribute to further medical and dental problems; or
5. _____other alternative (please describe) ________________________________________

SEND YOUR RESPONSE BY OCTOBER 6, 1995 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.
Confidentiality for an Eating Disorders Patient?

Response to Ethical Dilemma #24

Ashley Jacobs is a new patient in your general practice who has recently moved with her family from Seattle. Her father is in the oil and gas business and the family has moved six times in the last four years. She is 16 years old and her mother reports that she is in good health. Her vital signs are within normal limits and she has had the usual childhood diseases.

Your first impression is that she looks very thin at 5'4" and 105 pounds. She has received yearly dental examinations, and her mother notes that she has had few fillings although her teeth have been more sensitive to cold these last three years. Ashley stopped eating ice cream and drinking cold drinks about the same time, and her mother notes that her weight is about the same since then.

Ashley has a quiet, pleasant demeanor and answers questions with a yes or no. As you begin your examination, she immediately asks, "please don't use water or air on my teeth." Her previous dentists, she explained, avoided using cold water or air. The oral examination reveals mild to moderate enamel loss due to acid erosion on the lingual surfaces of the maxillary centrals and laterals.

As you ask if she ever has any problem with "sour stomach" or vomiting, she becomes very nervous and upset. "How do you know that?" she asks and says "maybe I have an occasional problem with vomiting." You explain that acid from vomiting causes erosion of the enamel and that chronic vomiting may be a serious health problem. Ashley breaks down and admits that she frequently self-induces vomiting. She and a few friends have the "same problem." She pleads, "please don't tell my mother, she'll just freak out! I'm better now and my mom doesn't need to know."

Dentists who responded to the case chose three alternatives, including: 1) ask Ashley to tell her mother or you will; 2) inform Ashley that you will inform her mother, as you are concerned for her health; and 3) inform Ashley that she may need professional help and that not telling her parents may contribute to further medical and dental problems. None of the respondents chose to follow Ashley's recommendation to avoid telling her mother. Other alternatives were described that will be included in the discussion.

Ashley presents an ethical dilemma because each action may have consequences that are harmful to her physical or emotional health. If her condition is revealed to her mother, Ashley may suffer psychological harm. She may also lose trust in the dentist who does not respect her request and breaks confidentiality. We will examine three elements of this case: 1) the dental/medical aspects of anorexia and bulimia nervosa; 2) keeping and breaking confidences; and 3) a hierarchy of values: general health, oral health and autonomy.

Anorexia and Bulimia Nervosa

Most dentists reading Ashley's case would not be surprised by her disclosure that she frequently self-induces vomiting. The dental signs associated with eating disorders like anorexia nervosa have been described as early as 1970 (1,2). In 1980, bulimia nervosa was identified as a separate eating disorder characterized by binge eating followed by purging behavior such as self-induced vomiting by the patient (3). Both disorders are described in Table 1 (4).

Ashley presents with two common dental signs of chronic vomiting — demineralization of anterior enamel and smooth erosion of the lingual surfaces of maxillary anterior teeth with accompanying sensitivity (5). While patients like Ashley may be silent about their eating disorders, their physical and oral signs may be painfully evident. Dentists and dental hygienists may be the first health professionals to detect an undiagnosed eating disorder (5,6,7,8).

Ashley seems genuinely surprised when the dentist asks if she has any problem with "sour stomach" or vomiting and explains about enamel erosion and the serious health problems associated with chronic vomiting. Her social history revealed that she has moved six times in the last four years. That may be a factor in her disorder. Her mother observes that she stopped eating ice cream and drinking cold drinks three years ago, about the same time she failed to make appropriate weight gain. Ashley reports that the sensitivity was present at previous dental visits. From the patient's history, one could speculate that the eating disorder has persisted for at least three years.

Some dental signs in Ashley's case are directly attributable to her self-induced vomiting. However, other oral findings not associated with Ashley's case could include: raised appearance of amalgams in posterior teeth; moth-eaten appearance of the incisal edges of
the maxillary teeth; a possible open bite of the anterior teeth; sore throat (from chronic acid reflux); burning tongue; bleeding gingiva; salivary gland enlargement causing a square-looking facial appearance; and dental caries due to the chronic acid exposure and the high intake of simple carbohydrates (5,6,7,8).

The oral signs and the disclosure by Ashley are sufficient to establish that she probably has an eating disorder. What is the obligation of the dentist to the patient and her family to inform, educate and refer the patient for proper medical and psychiatric counseling? One respondent said, “I would want someone to tell me if my daughter was harming herself.” Not intervening in her disorder is vexing because “an acceptable prognosis for dental treatment depends on cessation of binge eating and vomiting habit” (6). When the dentist chooses to treat the patient’s symptoms, he or she may be ignoring a life-threatening condition. Is protecting Ashley’s general health sufficient reason to override the obligation to keep her disorder confidential?

Keeping and Breaking Confidences

The proper doctor-patient relationship depends on a collaboration about symptoms, personal values, histories, and findings in a setting of mutual trust. Mutual trust cannot exist without the assurance of confidentiality.

The philosopher David Ozar describes confidentiality in this way: “The accepted standard is that every fact revealed to the health professional by a patient is, in principle, subject to the requirement of confidentiality, so that nothing may be revealed to anyone else without the patient’s permission” (9). The philosopher Tom Beauchamp refers to confidentiality, telling the truth (veracity) and privacy as principles that are all derived from the principle of autonomy, or respect for persons. Beauchamp explains, “To respect persons is to see them as unconditionally worthy agents, and so to recognize that they should not be treated as conditionally valued things that serve our own purposes (10).”

Confidentiality is a principle of ethics in the AMA Code. The Code recommends that “the physician should not reveal confidential communications or information without the consent of the patient, unless provided for by the law or by the need to protect the welfare of the individual or the public interest.” Protecting Ashley’s welfare is central to this case. In keeping with the history of the AMA Code, there is also a description of the patients’ responsibility to physicians: “Good communication is essential to a successful physician-patient relationship. To the extent possible, patients have a responsibility to be truthful and to express their concerns clearly to their physician (7). However, confidentiality is not an absolute principle, since a doctor can and should override this principle to warn others, the public, or if required by law (11).

The central issue in Ashley’s case is whether the dentist should respect the confidentiality for a minor. As one dentist said, “her parents are the responsible parties, pay the bills and should (must) be told what the doctor finds and what he thinks should be done to preserve or recover his patient’s health.” Another dentist remarked: “Ashley is a minor. The parents will need to be informed of the dental findings and their probable cause. The dental problems will need to be addressed by the dentist through her parents.” There is some agreement in the literature that intervention for the eating-disorder patient is appropriate. However, any attempt at intervention may result in the patient who may temporarily or permanently leave the practice (8,12,13). Though the ADA Code does not provide guidance in this area, the AMA Code offers the following:

“In cases when the physician believes that without parental involvement and guidance the minor will face a serious health threat, and there is reason to believe that the parents will be helpful and understanding, disclosing the problem to the parents is ethically justified. When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure (11).

Hierarchy of Values: General Health, Oral Health, and Patient Autonomy

The doctor must decide if a “serious health threat” exists before breaching the confidentiality of the minor. The question of the level of harm is a complex matter. The philosopher David Ozar has proposed a hierarchy of central values to better understand these issues (9).

At the top of the hierarchy is the value of the patient’s life and general health, as every treatment recommended or performed by the dentist must consider this value. The dentist would be acting unprofessionally if he or she failed to consider treatment that would place the patient’s life and general health at risk. For example, the decision to do periodontal surgery for the noncompliant patient who refuses to take antibiotics to prevent infective endocarditis places the patient’s life and general health at risk. Dental hygienist Barbara Altsheuler recommends informing parents or guardians of the eating-disorders patient. “The severe medical complications — including mortality — associated with eating disorders, intervention must be attempted, regardless of the outcome” (8). Ranked second on the hierarchy is the value of the patient’s oral health, including appropriate and pain-free oral function. Due to her eating disorder, Ashley’s oral health is neither appropriate nor pain-free. If her disorder continues, the prognosis for her oral health will worsen. Third on
It is the end of a busy Saturday. You purchased the practice four years ago and established your general practice in the suburbs. Although it was a struggle for two years, it has been very busy since then. Your office is across from a large parking lot and, as usual, a group of boys is playing roller hockey. As you prepare to leave for the afternoon, some boys enter your office and one is holding his mouth.

“He just got hit by a hockey stick and it knocked out his front tooth,” said one of his friends. “Here’s the tooth. We didn’t know whether to just throw the tooth away and saw your office.”

As you are standing in the reception area, you notice that besides a slight abrasion and some swelling of the lip, he doesn’t appear to be seriously injured, other than the avulsed maxillary left central incisor. The sight of the avulsed tooth distresses the injured boy. As you examine the tooth held by his friend, you notice that the crown and root are intact and free of debris.

You question the injured boy about how you can reach his parents and the name of his dentist. “He’s staying with me for the weekend” says the boy holding the tooth. “My parents won’t be home until late tonight.” After further questioning, you realize you will be unable to reach any parent for several hours. Also since his family moved to town six months ago he has not been to a dentist and he is unable to remember the name of his previous one. He is in the eighth grade at the local public school.

His friend asks again, “should we throw this tooth away?”

You are now faced with an ethical dilemma. Check the course(s) of action that you would recommend and mail or fax this page, or a note suggesting your recommendation, as instructed below:
1. ______ advise the boy to go to the emergency room at the local hospital for treatment and tell him not to throw the tooth away;
2. ______ refer the boy to an oral surgeon that you know is on call this weekend and tell him not to throw the tooth away;
3. ______ tell the boy you will be unable to treat him without a parent’s consent and tell him not to throw the tooth away and to call when a parent can be reached;
4. ______ explain the need to replant the tooth immediately and the risks involved and perform the procedure upon his approval; or
5. ______ other alternative (please describe)

SEND YOUR RESPONSE BY DECEMBER 7, 1995, 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.

Conclusion

Confidentiality is a core element in a successful doctor-patient relationship and is the basis for mutual trust. Patients with eating disorders present an ethical dilemma, since they may deny the existence of this serious health problem. However, dentists who understand the symptoms of eating disorders may be the first health professionals to identify an undiagnosed case. The dentist has the responsibility to all patients, whether adult or minor, to educate them about the risks and complications to their general and oral health. This will include the need for further medical referral and possible psychiatric counseling. In cases of minors with eating disorders, the dentist has a more stringent obligation to encourage the patient to discuss the eating disorder with parents or guardians. If after these efforts Ashley continues to resist telling her mother, the dentist is ethically justified in breaking confidentiality.

References
4. Diagnostic and statistical manual of mental disorders: DSM-IV. ed. 4 American Psychiatric Association,

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, for fax to (214) 828-8952.

### Table 1: Diagnostic criteria for 307.1 Anorexia Nervosa include:

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<th>A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 15% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 15% of that expected).</th>
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<tr>
<td>B. Intense fear of gaining weight or becoming fat, even though underweight.</td>
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<tr>
<td>C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.</td>
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| D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration).  
**Specify Type:**  
**Restricting Type:** during the current episode of anorexia nervosa, the person has not regularly engaged in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)  
**Binge-Eating/Purging Types:** during the current episode of anorexia nervosa, the person has regularly engaged in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). |

**Diagnostic criteria for 307.51 Bulimia Nervosa include:**

| A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:  
(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances  
(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).  
| B. Recurrent, inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medication; fasting; or excessive exercise.  
| C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.  
| D. Self evaluation is unduly influenced by bodyshape and weight.  
| E. The disturbance does not occur exclusively during episodes of anorexia nervosa.  
**Specify Type:**  
**Purging Type:** during the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.  
**Nonpurging Type:** during the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.  

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