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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Permission

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Support

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

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Version 1
2008
Frank Matthews has agreed to be a backup patient for the Dental Regional Board Examination. He is a friend of Dr. Mark Arden, a candidate who is taking the Board for the first time. Frank and Dr. Arden have known each other for three years.

Frank, a healthy 50-year-old computer technician, is also a patient at the dental college. He has had few dental needs in the past, but admits to being “dental phobic.” He tolerates treatment but is usually anxious. Dr. Arden is planning a conservative MOD inlay casting for Frank for tooth #13 if the examiners reject his primary patient.

On the day of the Board, the examiners accept Dr. Arden’s primary inlay patient, much to Frank’s relief. However, Dr. John Willis, a classmate, pleads with Mark, “my patient just called and can’t come in — can I use your backup patient?” Mark asks Frank if he would be willing to be a patient for his classmate, and Frank reluctantly agrees.

The appointment went well and the inlay preparation for Frank was conservative. But during the casting try-in, the inlay fit so tightly that Dr. Willis could not dislodge the restoration. As time was running out and the casting fit was excellent, Dr. Willis decides to submit the casting as if it was cemented. He asks Frank: “Look, I can’t get the inlay out and we’re almost out of time. I am going to have the examiners evaluate this as it is. When I get my dental license, I will redo the inlay. Just don’t say anything to the examiners.” As Frank leaves to have the post-cementation evaluation, he sees Dr. Arden, explains the situation and asks, “the inlay isn’t cemented...should I say something to the examiners?”

Mark is now facing 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. ______ talk to John first and defer the question from Frank;
2. ______ advise Frank to tell the examiners that the casting isn’t cemented;
3. ______ advise Frank to follow the instructions of Dr. Willis;
4. ______ advise Frank to talk to Dr. Willis about these concerns; or
5. ______ other alternative (please describe)

SEND YOUR RESPONSE BY NOVEMBER 8, 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.
Dental Clinical Examining Board Dilemma
Response to Ethical Dilemma #25

Frank Matthews has agreed to be a backup patient for the Dental Regional Board Examination. He is a friend of Dr. Mark Arden, a candidate who is taking the Board for the first time. Frank and Dr. Arden have known each other for three years.

Frank, a healthy 50-year-old computer technician, is also a patient at the dental college. He has had few dental needs in the past, but admits to being "dental phobic." He tolerates treatment but is usually anxious. Dr. Arden is planning a conservative MOD inlay casting for Frank for tooth #13 if the examiners reject his primary patient.

On the day of the Board, the examiners accept Dr. Arden's primary inlay patient, much to Frank's relief. However, Dr. John Willis, a classmate, pleads with Mark, "My patient just called and can't come in — can I use your backup patient?" Mark asks Frank if he would be willing to be a patient for his classmate, and Frank reluctantly agrees.

The appointment went well and the inlay preparation for Frank was conservative. But during the casting try-in, the inlay fit so tightly that Dr. Willis could not dislodge the restoration. As time was running out and the casting fit was excellent, Dr. Willis decides to submit the casting as if it was cemented. He says to Frank, "Look, I can't get the inlay out and we're almost out of time. I am going to have the examiners evaluate this as it is. When I get my dental license, I will redo the inlay. Just don't say anything to the examiners." As Frank leaves to have the post-cementation evaluation, he sees Dr. Arden, explains the situation and asks, "The inlay isn't cemented...should I say something to the examiners?"

Dentists who responded to the case chose to: 1) advise Frank to follow the instructions of Dr. Willis; 2) advise Frank to tell the examiners that the casting isn't cemented; and 3) advise Frank to talk to Dr. Willis about these concerns. None of the respondents chose to talk to John first and defer the question from Frank. The response includes several alternate recommendations.

Dentists share common experiences such as the first patient, the first extraction and a dental clinical board examination using live patients. There is a rich array of issues surrounding these examinations. We selected the ethical issues of licensure, live patients and irreversible procedures, and patient autonomy at risk.

Licensure, Live Patients and Irreversible Procedures

One original purpose for dental licensure was to protect the public from "untrained or poorly trained practitioners." The founding of the Baltimore College of Dental Surgery in 1840 marked the beginning of formal dental education and the separation of dental and medical education in the United States. Though the practice of dentistry was wide open initially, states decided to require licensure through the enactment of dental practice laws. Alabama, for example, passed the first dental statute in 1841, with each jurisdiction subsequently enacting legislation including licensure examinations (1). Texas passed its first dental law March 27, 1889 (2).

Today, the general requirements for licensure in the United States include: 1) graduation from an accredited U.S. dental school; 2) successful completion of a two-part national written examination; 3) successful completion of written and clinical examinations administered by the state or other designated organizations (e.g., a regional board); and 4) a "jurisprudence" examination to check familiarity with specific state practice laws (3). While states uniformly accept the national written examination, there is no national standard for the clinical examination. Four regional boards and twelve individual states conduct clinical examinations. Candidates may practice within regions or individual states as defined by each examination except states offering reciprocity or licensure by credentials.

Dentistry is unique in its licensing process. Dentistry is the only health profession that requires the performance of irreversible patient treatment as a part of a clinical examination. Some medical specialty organizations use standardized patient examinations (e.g., professional patients who feign a condition) to assess the candidate's ability to interview, diagnose and provide a treatment plan. For optometry in some states, candidates perform certain diagnostic procedures. None of these examinations, however, subject patients to therapeutic or irreversible interventions (3).

Frank Matthews in our case has agreed to be a patient for the dental clinical examination. The irreversible treat-
ment provided by his candidate is incomplete, but the candidate is asking the patient to keep information from the examiners. Should Frank support his candidate and not say anything to the examiners? Should he support the purpose of the examination and reveal the deficiency to the examiners? Is the patient’s primary obligation to his candidate, the examiners or himself?

**Patient Autonomy at Risk**

The benefit of the patient should be the primary goal of dental practice, according to the ADA Code (4). The artificiality of the clinical examination, however, creates an unusual tension between the candidate’s desire to care for the patient’s best interest while promoting his or her own self-interest in passing the exam. What is at stake is the privilege to practice one’s profession and what is at risk is the respect for patient autonomy.

The term “autonomy” is derived from the Greek autos (self) and nomos (rule, governance, or law). Self-rule or self-governance is a concept rooted in Western society and refers to “being one’s own person, without constraints either by another’s action or by psychological or physical limitations (5).” Autonomy in health-care ethics encompasses the principle of respect for persons. Since patients are moral agents, respecting autonomy means that health professionals value patients unconditionally, as an end in themselves. We should not use patients as a means to an end (6). If we respect Frank Matthews’ autonomy, then he should not be “used” as a board patient, but treated as any patient in dental practice. Recognition of personal autonomy is the basis for other duties to the patient such as seeking informed consent, truthfulness, and confidentiality (7). The ADA Code offers advisories about these duties of which the first two relate directly to the case.

The ADA Code addresses informed consent (Section 1-M. Patient Involvement) by affirming, “The dentist should inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions (4).” Coercing patients to accept certain treatments, even on the board exam, corrupts informed consent (8). For example, a candidate may pressure a patient to accept a gold casting that is a board requirement when the patient would prefer a tooth-colored restoration. When asked about their board experience, 21 percent of 250 graduates who responded to a survey reported coercing patients into accepting a particular treatment (9). Reluctant patients may be coerced by promises of free dental treatment or even being paid if they agree to participate. Because patients who agree to sit for the board exam are test subjects, in essence, “guinea pigs,” it is more important than ever that students and especially the profession secure their rights.

The ADA Code addresses truthfulness (Section 1-K Representation of Care) by stating, “Dentists shall not represent the care being rendered to their patients in a false or misleading manner (4).” Truthfulness is the central issue of this case since Dr. Willis has asked the patient not to reveal the uncemented inlay dilemma to the examiners. As one dentist observed, “If Dr. Willis will lie about the inlay, what is he capable of when he gets into private practice?” Another remarked, “Dr. Willis should explain his problem to the examiner. If there are honest people on the examining board, there should be no problem with his being honest with them.” Taking exception, another dentist advised, “Having been there, I would not stake 4-6 months of my professional career on assuming the board would appreciate my idealism. Advise Frank to relay his concerns to Dr. Willis.” From the previously cited survey, 30 percent of the candidates reported provision of premature restorative treatment and 37 percent reported taking unneeded X-rays. Were candidates truthful with their patients about these occurrences?

These factors add to the emotional stress associated with the examining boards (10), a stress rarely encountered in the “real world” (8). A dentist remarked, “If this happened in your office, you would remove it (the inlay) and cement. You would not have a time limit.” These and other factors have led to recommendations for restructuring licensure that would include eliminating examinations using live patients for the performance of irreversible treatment (3, 11).

**Conclusion**

The responses indicated that dentists are well aware of the problems facing those applying for licensure. Requiring the performance of irreversible treatment for live patients on examining boards places the respect for patient autonomy at risk. The real problem in the case is that Frank Matthews should not be faced with this dilemma. Clinical boards should grant special consideration for extenuating circumstances to remove the burden of unethical practice. This sends the right message to the patient and to the new practitioner: the rights of the patient are more important than licensure. When a profession fails to intervene where patient autonomy is compromised, then the profession’s integrity is at risk. Entry into the profession should not place dentists in a position where they must choose to be unethical to qualify to practice their profession.

**References**

3. Dental schools, the profession, and the public. In: Field MJ, ed. Dental

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.

Dr. Jack Lange has been practicing general dentistry with an emphasis on cosmetics as an associate of Dr. Cheryl Sims for four years. Initially, both practices have prospered and there are plans for a partnership with an emphasis on practicing cosmetic dentistry. However, over the last six months, both practices have seen little growth. As a result, Dr. Sims decided to launch an advertising campaign, since she was concerned about this downturn.

Although both dentists have had small advertisements in the past, Dr. Sims is considering a quarter-page ad for the new telephone book. At the end of the day, Dr. Sims hands a rough sketch of the ad to her partner and says, "Look at this and let’s finish the ad.”

Cheryl Sims, D.D.S. and Jack Lange D.D.S.
“We specialize in making your smile beautiful.”*

*All treatment is guaranteed for three years.

Upset about the implications of the ad, Dr. Lange declares, “This ad is unethical and I’ll have no part of it!” Dr. Sims responds that the ad will help them prepare for their partnership. “Look,” explains Dr. Sims, “there are several reasons why it is not unethical! First, we are talking about cosmetic, not reconstructive dentistry. Many cosmetic-related businesses such as eyewear companies guarantee their products, so why should dentists be any different? Besides, we already replace most failed treatment anyway within three years. I believe that dentists should guarantee their work just like other services!” The arguments sounded convincing, and Dr. Lange finds himself doubting his original view.

Dr. Lange is facing an ethical dilemma. Check the course(s) of action that you would recommend and mail or FAX this page, or a note suggestion your recommendation, as instructed below:
1.____ send the advertisement as is;
2.____ remove Dr. Lange’s name and send the advertisement;
3.____ Dr. Lange should have the advertisement delayed and sent to the State Board of Dental Examiners for comment;
4.____ have the ad delayed and contact a lawyer about the legality of the advertisement; or
5.____ other alternative. (please describe)

SEND YOUR RESPONSE BY JANUARY 8, 1996, 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.