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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2008
Ethical Dilemma

What Would You Do?

Ethical Dilemma #29

Mr. Jack Haney is a 46-year-old emergency patient referred to you by his sister, who has been in your general practice for four years. Mr. Haney is in good health except for mild hypertension that he is managing with diet and exercise.

His maxillary right second bicuspid has “bothered” him on occasion over three years. As a salesperson for sports-wear, he has been traveling and receives episodic dental care. The tooth has been draining through a gingival sinus tract on the buccal mucosa at the level of the root apex. Radiographs reveal a 6-mm diameter radiolucency lesion at the apex. The tooth exhibits no percussion sensitivity and only occlusal caries. The clinical signs and symptoms are consistent with the diagnosis of a necrotic pulp. Due to the curvature in the apical one-third of the root you decide to refer Mr. Haney to the new endodontist in the community, Dr. Doug Evans.

Dr. Evans completed the root canal treatment in three appointments. The access opening was closed with IRM and Mr. Haney received instructions about being careful when he eats. He was returned to you to start the fixed partial denture.

Last night as Mr. Haney was eating, he felt a “crunch” and discovered a fragment of tooth in his food. There was no pain so he decided not to call and to keep his appointment with you today. Your examination reveals that the bicuspid has fractured well beyond the gingival attachment level and that the tooth cannot be restored. You describe the reason that the tooth needs to be extracted and that a three-unit porcelain fixed partial denture is recommended after the site has healed.

Mr. Haney states, “Say, I didn’t bargain on this happening and I would like to have what I already paid to Dr. Evans applied to the cost of three-unit porcelain bridge!” As you explain that these problems rarely happen, he replies: “Look, this must have been a poor job—I would not have paid for the root canal if I knew this would happen. I don’t care who made the mistake, but I am only paying for the cost of the bridge minus whatever I paid Dr. Evans.”

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

1. subtract the root canal payment from the standard cost for a three-unit fixed partial denture and have the patient pay the reduced cost;
2. insist that Mr. Haney pay the full amount for the fixed partial denture;
3. call Dr. Evans and have him reimburse the patient for the full cost of the root canal;
4. dismiss Mr. Haney from your practice; or
5. other alternative (please describe)

EDITORS COMMENT: E-mail has been added to the ways that the members can respond to the cases. All correspondence is strictly confidential including responses and cases that a member may want to submit for publication. 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, FAX to (214) 828-8952, or E-mail to: tk.hasegawa@baylormedical.edu.

SEND YOUR RESPONSE BY APRIL 8, 1996, ATTENTION: Dr. Thomas K. Hasegawa, Jr., Department of General Dentistry, Baylor College of Dentistry, P.O. Box 660677, Dallas, TX 75266-0677, FAX to (214) 828-8952 or E-mail to: tk.hasegawa@baylormedical.edu.
“The Patient Fractures His (RCT) Tooth—Who is Responsible”
Response to Ethical Dilemma #29

Mr. Jack Haney is a 46-year-old emergency patient and was referred to you by his sister who has been in your general practice for four years. Mr. Haney is in good health except mild hypertension that he is managing with diet and exercise.

His maxillary right second bicuspid has “bothered” him on occasion over three years. As a salesperson for sportswear, he has been traveling and receives episodic dental care. The tooth has been draining through a gingival sinus tract on the buccal mucosa at the level of the root apex. Radiographs reveal a 6-mm diameter radiolucent lesion at the apex. The tooth exhibits no percussion sensitivity and only occlusal caries. The clinical signs and symptoms are consistent with the diagnosis of a necrotic pulp. Due to the curvature in the apical one-third of the root you decide to refer Mr. Haney to the new endodontist in the community, Dr. Doug Evans.

Dr. Evans completed the root canal treatment in three appointments. The access opening was closed with IRM and Mr. Haney received instructions about being careful when he eats. He was returned to you to start the fixed partial denture.

Last night, as Mr. Haney was eating, he felt a “crunch” and discovered a fragment of tooth in his food. There was no pain so he decided not to call and to keep his appointment with you today. Your examination reveals that the bicuspid has fractured well beyond the gingival attachment level and that the tooth cannot be restored. You describe the reason that the tooth needs to be extracted and that a three-unit porcelain fixed partial denture is recommended after the site has healed.

Mr. Haney states, “Say, I didn’t bargain on this happening and I would like to have what I already paid to Dr. Evans applied to the cost of three-unit porcelain bridge!” As you explain that these problems rarely happen, he replies: “Look, this must have been a poor job — I would not have paid for the root canal if I knew this would happen. I don’t care who made the mistake, but I am only paying for the cost of the bridge minus whatever I paid Dr. Evans.”

Dentists who responded to this case either insisted that Mr. Haney pay the full amount for the fixed partial denture, or offered other financial alternatives. None of the respondents chose the following options: 1) subtract the root canal payment from the standard cost for a three-unit fixed partial denture and have the patient pay the reduced cost; 2) call Dr. Evans and have him reimburse the patient for the full cost of the root canal; or 3) dismiss Mr. Haney from your practice.

Was Mr. Haney justified in claiming that this was a “poor job” and should he receive credit for the cost of the root canal? We will examine three issues in this case, including: 1) bad outcome or mistake; 2) justice or public relations; and 3) preventing ethical problems.

Bad Outcome or Mistake?

Mr. Haney asserts that there was a “mistake” made by the generalist or the endodontist in this case and that the bad outcome of the case was the result of the “poor job” by the practitioners. Is Mr. Haney’s claim for credit for the root canal cost justified?

The general dentist elected to refer the case to the endodontist because the curvature of the apical one-third of the bicuspid was beyond the generalist’s competence. While general dentists perform root canal therapy, they are expected to refer cases to specialists that are beyond their competence. The TDA Code recommends that dentists should “recommend referral when the welfare of the patient or quality of care will be safeguarded or enhanced hereby (1).” Likewise, the ADA Code states, “Dentists shall be obliged to seek consultation, if possible, wherever the welfare of patients will be safeguarded or advanced by utilizing those who have special skills, knowledge, and experience (2).” If clinicians intend to keep the “benefit of the patient (2)” as their primary goal, then providing competent care also requires referring cases requiring special skill, knowledge and experience.

The endodontist was practicing competently by properly sealing the coronal access opening with IRM to avoid leakage and contamination of the root canal prior to returning the patient to the general dentist (3). Dr. Evans also properly informed the patient to be “careful” when he eats, as tooth fracture is another potential risk due to the weakness caused by the loss of coronal and radicular dentin during access opening and canal preparation (4).

Endodontic treatment is thought to increase brittleness of teeth, making them more susceptible to fracture. Actually, studies show there is only a small reduction in strength as a result of endodontic therapy. The latter causes only a 5% loss of resistance to fracture (due to the removal of tooth structure in the access opening) as compared to a 63% loss resulting from a MOD cavity preparation. Endodontic procedures cause essentially no weakening of teeth with intact marginal ridges, as in the case of Mr. Haney (5).

Treatment alternatives are available and appropriate, especially if a tooth is extensively involved with caries or a large restoration, and/or if there is heavy occlusal wear due to bruxism. The endodontist could choose to reduce the tooth out of occlusion to prevent crown/root fracture, although there is some risk for supereruption of the opposing and/or treated tooth (6). The endodontist could restore the tooth with a bonded core build-up after obturation, thereby strengthening the tooth and increasing the resistance to microleakage (4). The referring dentist could prepare the tooth for a crown and place a provisional restoration that could be removed and reused by the endodontist during treatment (4).

Respondents wrote that “no one is to blame” for the loss of the bicuspid, that it is an “unfortunate incident,” and that “unfortunate outcomes happen on occasion.” That is, “any tooth can fracture, even one without a restoration” and “teeth are like
diamonds, bite or get hit the right way and snap.” While bad outcomes may be caused by bad work (7), in this case both clinicians were practicing within accepted standards of care.

**Justice or Public Relations?**

While there was general agreement that neither practitioner made a “mistake,” there was less agreement on the question of whether Mr. Haney should receive credit for the cost of the root canal treatment for a tooth that must now be extracted.

Responses ranged from no credit for Mr. Haney (he pays the full cost of the fixed partial denture) to full credit for the root canal (the endodontist refunds half the fee and the general dentist reduces the cost of the fixed partial denture by half the cost of the root canal). An endodontist noted that while specialists may allow for fractures that occur during root canal treatment, that is not the case after the case is completed.

Justification for crediting for the cost of the root canal centered on three issues: retention of the patient to maintain public relations (PR), avoidance of peer review or litigation, and compliance with the profession’s codes of ethics.

Retention of the patient had both PR and financial incentives. As one dentist explained, “As a professional, I believe our fees should reflect a no-fault correction of the occasional untoward outcome. If everyone gives a little, everyone wins...the patient gets his bridge and can be a positive PR source for you and the endodontist.” Another dentist remarked, “Doing the bridge would not take much longer than two crowns and you could still make a profit on it.” Another PR and financial incentive is that Mr. Haney’s sister could choose to leave the practice if he leaves the practice.

A second justification for the allowance was to avoid the peer review system or litigation. As a dentist noted, “One might choose to do the bridge for the reduced fee just to keep the peace.” Another remarked that the local dental “peer review system is really a ‘public relations’ organization, to promote public relations. I have seen dentists who were directed to return fees even though they did nothing wrong.”

The third justification was that the dental codes of ethics might require the allowance. One dentist asked, “Why would doctors or dentists need a special set of rules? Maybe we would like some exemptions for some rules, but we sure don’t need a special set.” The ADA Code does place the “benefit of the patient (2)” as our profession’s primary goal, and it does ask that dentists be “caring and fair” and provide “quality care in a competent and timely manner (2).” The ADA Code does not, however, admonish dentists to put PR first or to practice primarily by protecting their assets.

The question of fairness is what this case is about. There was a bad outcome resulting in the extraction of Mr. Haney’s tooth, but it was not the result of the care by either practitioner. For ethics, the principle of justice relates to fairness or “what is deserved.” That is, “a person has been treated justly when he or she has been given what he or she is due or owed, what he or she deserves or can legitimately claim (8).” None of the respondents argued that Mr. Haney had a legitimate claim to any allowance for the financial loss of what was paid for the root canal, although some chose this alternative for the three aforementioned reasons.

**Preventing Ethical Problems**

Perhaps a clear message in the responses to this case relates to the value of preventing ethical problems in practice. The ethicist Edmund Pellegrino describes the value of preventive ethics in medicine: “Preventing ethical conflict, confusion, and misunderstanding is analogous to preventing or containing disabling or chronic illness. Preventive ethics is less expensive, more effective, and less traumatic emotionally than litigation, bureaucratic regulation, or misunderstandings between physicians, patients, and families (9).” Preventing problems in practice is consistent with the maxim *primum non nocere* — “above all, or first, do no harm” — which is commonly referred to as the ethical principle of nonmaleficence (10).

Practicing preventive ethics can occur first by improving communications with patients regarding questions of consent and the realities of the limitations of our knowledge, materials, and skills to predict or prevent all untoward outcomes. General dentists could practice preventive ethics by communicating carefully with all specialists in an ongoing dialogue so that patient expectations are realistic. Finally, dentists can practice preventive ethics by continuing to discuss cases like Mr. Haney’s with their colleagues towards learning how to avoid future occurrences.

**Conclusion**

Mr. Haney’s claim that his fractured tooth was the result of a “mistake” or “poor job” was not justifiable. Dentists are obligated to be competent, caring and fair with patients, but not to be responsible for every untoward outcome. While dentists may choose to offer some credit to Mr. Haney, they would not be ethically required to in this case.

**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. Dr. John Harrison is a Professor in the Department of Restorative Sciences at Baylor College of Dentistry. 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, fax to (214)828-8952, or E-mail to: tk.hasegawa@baylor.edu

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