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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Mr. Tom Allen is a new patient in your general practice who admits being a dental phobic. In fact, it has been eight years since his last dental exam. He is 42 years old and owns the hardware shop in your town of 25,000 people. Tom says he is in good health, although he is overweight and admits that he has smoked a pack-a-day for twenty years and drinks two or three beers every day. He has a yearly physical, and his vitals are within normal limits. His chief complaint is that within the last six months, his molars on the left side started to feel “loose” and the gums would bleed easily on brushing. Also, his face felt slightly swollen in the area, although there was no pain currently from the teeth or gums. He had painful episodes that he attributed to a toothache in the same area when the bleeding first started. His friends told him he probably had “pyorrhea” and needed his teeth “scraped.” One of his employees gave him your name.

Your examination reveals firmness of the lymph nodes in the left neck, but the nodes are not tender. Intraorally, all the soft tissues appear within normal limits, except for the gingival on the mandibular left. In the area of the first molar there is a raised, somewhat papillary red and white irregular lesion of 1 x 2 cm that is firm on palpation. The first molar appears to be healthy except for a Class III mobility as the tooth is compressible. His periodontal condition is normal in the other quadrants. Radiographs show complete bony destruction that extends to the apices from the mesial of the second molar to the mesial root of the first molar. The teeth appear to be “floating in air,” as the borders of the lesion are neither sclerotic or defined. The last time you saw this type of lesion was when you were in dental school 5 years ago and you suspect a possible malignancy.

Tom asks: “Is it cancer? My father died of mouth cancer when he was 50.” He admits to you that his fear of the dentist was the result of seeing his father suffer for six months before he died. He again says, “Tell me, is this cancer? I don’t know what I will do if it is cancer!”

You reassure Tom that although the lesion appears suspicious, a biopsy is necessary to establish the diagnosis. You also mention the name of an oral surgeon who you recommend to perform the procedure. Tom is obviously shaken and implores you to do the biopsy and be the doctor to discuss the findings — he trusts you even if he is phobic about dentists. You have performed a number of biopsies in the past and his request is not unreasonable.

The incisional biopsy surgery went without complications, other than Tom requiring preoperative sedation. The biopsy sample was wedge shaped, approximately 3 x 5 mm taken from the buccal gingiva of the lower left first molar. You mailed the sample to an oral pathology service with instructions to fax the results to your office. Within 24 hours, the laboratory faxed the results of the biopsy. The FAX is on page 48 (NOTE: all names on the FAX are fictitious).

You immediately call the oral pathologist, Dr. Grimes, who confirms the diagnosis and explains the grave prognosis of Tom’s malignancy. Dr. Grimes explains that even with radical surgery, radiation therapy and chemotherapy, the five-year survival rate is estimated at 10% to 30%. You then call to schedule Tom for a consultation and his spouse, Ann, answers the phone. Ann tells you that Tom is so frantic that she is worried that he may do something “desperate” if he is told he has a malignancy. She pleads with you not to tell him now, even if it is malignant, but to delay this stress a few days. “Tell him you need a second opinion, another lab test — anything. If you tell him now,” she explains again, “I’m not sure what he will do!” You make the consultation appointment for Tom for the following day and consider what you will do.

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. ___________ at the consultation appointment, inform Tom that he has oral cancer, what generally needs to be done, but do not mention the poor prognosis;
2. ___________ at the consultation appointment, inform Tom that he has oral cancer, what generally needs to be done, and discuss the poor prognosis with him;
3. ___________ follow his wife’s advice and call Tom to inform him that you need a (fictitious) “second opinion” and that this will take another week;
4. ___________ you call the oral pathologist, Dr. Grimes again to ask if he will break the news to Tom;
5. ___________ call Tom and ask him to see an oncologic surgeon to discuss the status of his biopsy; or
6. ___________ other alternative (please describe): ________

SEND YOUR RESPONSE BY July 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@baylorDallas.edu

TExAS DENTAl JOURNAL / 49
“Bad News Bearers”
Response to Ethical Dilemma #33

Mr. Tom Allen is a new patient in your general practice who admits being a dental phobic. In fact, it has been eight years since his last dental exam. He is 42 years old and owns the hardware shop in your town of 25,000 people. Tom says he is in good health, although is overweight and admits that he has smoked a pack-a-day for twenty years and drinks two or three beers every day. He has a yearly physical, and his vitals are within normal limits. His chief complaint is that within the last six months, his molars on the left side started to feel “loose” and the gums would bleed easily on brushing. Also, his face felt slightly swollen in the area, although there was no pain currently from the teeth or gums. He had painful episodes that he attributed to a toothache in the same area when the bleeding first started. His friends told him he probably had “pyorrhea” and needed his teeth “scraped.” One of his employees gave him your name.

Your examination reveals firmness of the lymph nodes in the left neck, but the nodes are not tender. Intraorally, all the soft tissues appear within normal limits, except for the gingival on the mandibular left. In the area of the first molar there is a raised, somewhat papillary red and white irregular lesion of 1x2 cm that is firm on palpation. The first molar appears to be healthy except for a Class III mobility, as the tooth is compressible. His periodontal condition is normal in the other quadrants. Radiographs show complete bony destruction that extends to the apices from the mesial of the second molar to the mesial root of the first molar. The teeth appear to be “floating in air”, as the borders of the lesion are neither sclerotic or defined.

The last time you saw this type of lesion was when you were in dental school five years ago and you suspect a possible malignancy.

Tom asks: “Is it cancer? My father died of mouth cancer when he was 50.” He admits to you that his fear of the dentist was the result of seeing his father suffer for six months before he died. He again says, “Tell me, is this cancer? I don’t know what I will do if it is cancer!”

You reassure Tom that although the lesion appears suspicious, a biopsy is necessary to establish the diagnosis. You also mention the name of an oral surgeon who you recommend to perform the procedure. Tom is obviously shaken and implores you to do the biopsy and be the doctor to discuss the findings—he trusts you even if he is phobic about dentists. You have performed a number of biopsies in the past, and his request is not unreasonable.

The incisional biopsy surgery went without complications, other than Tom requiring preoperative sedation. The biopsy sample was wedge shaped, approximately 3x5 mm taken from the buccal gingiva of the lower left first molar. You mailed the sample to an oral pathology service with instructions to fax the results to your office. Within 24 hours, the laboratory faxed the results of the biopsy. The FAX is on page 33. (NOTE: all names on the FAX are fictitious).

You immediately call the oral pathologist, Dr. Grimes, who confirms the diagnosis and explains the grave prognosis of Tom’s malignancy. Dr. Grimes explains that even with radical surgery, radiation therapy and chemotherapy, the five-year survival rate is estimated at 10% to 30%. You then call to schedule Tom for a consultation and his spouse, Ann, answers the phone. Ann tells you that Tom is so frantic that she is worried that he may do something “desperate” if he is told he has a malignancy. She pleads with you not to tell him now, even if it is malignant, but to delay this stress a few days. “Tell him you need a second opinion, another lab test anything. If you tell him now,” she exclaims again, “I’m not sure what he will do!” You make the consultation appointment for Tom for the following day and consider what you will do.

Dentists noted that they would: 1) inform Tom that he has oral cancer, what generally needs to be done, but do not mention the poor prognosis; 2) inform Tom that he has oral cancer, what generally needs to be done, and discuss the prognosis with him; and 3) after following the actions in option #1, call Tom and ask him to see an oncologic surgeon or oncologist to discuss the status of his
biopsy. None of the respondents chose to call the oral pathologist, Dr. Grimes, again to ask him to break the news to Tom. Also no respondent chose the option to follow the patient’s wife’s advice and tell Tom that you need a (fictitious) “second opinion” in order to delay the disclosure. A number of other options were described and will be cited as follows.

Few maladies create more fear and anxiety for patients than the diagnosis of a malignancy. Patients who have had family members face the tragedy of cancer, like Tom, may react in this frantic, and perhaps even desperate, manner. Tom’s case is also complicated by his wife’s request to withhold information from her husband for a few days. We will examine the ethical issues related to this case including: 1) therapeutic privilege and 2) can disclosure be harmful?

**Therapeutic Privilege**

The courts recognize five exceptions to providing informed consent with patients including: a public health emergency, a medical emergency, an incompetent patient, therapeutic privilege, and the patient waiver. Therapeutic privilege—which deals with a decision by a doctor to withhold part or all of the material information from a patient in order to protect the patient from the harmful effects of disclosure—is the most controversial of the exceptions (1, 2).

The key question in Tom’s case is whether the dentist should follow Ann’s plea to delay informing Tom of his malignancy because of his desperate mental state. Will the disclosure of this information worsen his prognosis or possibly result in depression or even suicide? This question is an enduring dilemma, and challenge, of medical practice as revealed by the first AMA Code of Ethics pub-

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**ORAL PATHOLOGY LABORATORY**

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Tom Jackson, DDS, MSD
Edward Burnside II, DDS, MSD
Jack J. Grimes, DDS, MS

Date: 05/06/96 Path No.: D96-1778

**PATHOLOGY REPORT**

Patient’s Name: Allen, Tom Age: 42 Sex: M Race: C
Operated by: Dr. Thomas Smith Patient Reg. No.: 0001

Specimen: L Md. gingiva
Clinical Diagnosis: Squamous cell carcinoma

**GROSS DESCRIPTION**

Patient complaining of loose teeth in L Md. and bleeding gums. Asymptomatic now but pain in past. L cervical adenopathy, 1-2cm red and white papillary lesion along #19 buccal gingiva. #19 mobile and radiographs disclose destructive lucency without cortication.

**MICROSCOPIC DESCRIPTION**

Histologic examination reveals a wedge of oral mucosa containing a malignant and neoplastic proliferation of poorly differentiated epithelium. The surface epithelium is stratified squamous in type and it displays areas of dysplasia with ulceration. The connective tissue has been largely replaced by large islands of poorly differentiated basoloid epithelial cells showing central necrosis. The neoplasm displays significant mitotic activity and an invasive growth pattern. In focal areas of the neoplasm there is squamous differentiation with small amounts of keratin produced. The neoplasm extends to all surgical margins.

**DIAGNOSIS** — Left posterior mandibular gingiva: Basaloid squamous cell carcinoma.

**COMMENT:** The basaloid squamous cell carcinoma is a newly described variant of oral cancer. Most patients will have regional metastasis at the time of diagnosis and between a 1/3 and 1/2 of these patients will have or will develop distant metastasis.

**PATHOLOGIST**

Jack J. Grimes, D.D.S., M.S.
Ethical Dilemma

published in 1847:
“(T)he physician should be the min-
ister of hope and comfort to the sick;
that, by such cordials to the drooping
spirit, he may smooth the bed of
death, revive expiring life, and coun-
teract the depressing influence of
those maladies which often disturb
the tranquility of the most resigned
in their last moments. The life of a
sick person can be shortened not
only by acts, but also by the words or
the manner of a physician. It is, there-
fore, a sacred duty to guard himself
carefully in this respect, and to avoid
all things which have a tendency to
discourage the patient and to depress
his spirits (3).”

The Code reveals two central as-
sumptions about the power and the privi-
lege of the physician. First, there is the
assumption that the patient’s life can be
shortened by the disclosure of discourag-
ing or depressing information. It is un-
clear whether this refers to the quality or
quantity of life or by what yardstick this
loss is measured. There are no research
studies that can account for these variables.
Second, the admonition to “avoid all things”
that may discourage or depress the patient’s
spirit provides nearly limitless justifica-
tion for withholding disclosure.

While the Code recognized the need
for disclosure, it did permit some flexibil-
ity in the manner and time frame in which
a health care provider discloses that informa-
tion, depending on the mental state of
the patient.

Can Disclosure Be Harmful?
Tom Allen’s case focuses attention
on the relevant issues of disclosure in
what may be a worst-case scenario for
dentists: the patient with oral cancer. There
is an urgency and an element of the un-
known in this case. Is Tom competent to
hear the diagnosis or should the dentist
heed Ann’s advice?
The physician and psychoanalyst Jay
Katz proposes that silence, or in this us-
age nondisclosure, is deeply rooted in the
ethos of medicine for promoting and pro-
tecting the best interests of the patient (4).
This has been referred to as the benefi-
cence model of moral responsibility where
the physician seeks to create the greater
balance of good over harm for the patient.
The roots of this model are from ancient
Greece and derive from the claim by a
profession that it knows what is in the best
interest of those that are served (5). Is it in
Tom’s best interest to disclose information
about his malignancy if it results in
physical or psychological harm, or even
suicide? Is a primary ethical obligation to
“do no harm” upheld if harm to the patient
results from the disclosure? Katz asserts
that the question, should dire information
be shared with the patient, has divided
medicine for centuries, with the majority
of physicians siding with nondisclosure.

None of the respondents to the case
chose to heed Ann’s advice and deceive
and delay conveying the results of the
biopsy. Advice by respondents included
“utilize a team” to help the patient cope
with the disease, have counseling avail-
able or offer support by clergy. One den-
tist chose to have the consultation with
Tom in his physician’s office with the
dentist present. Others chose to refer Tom
to an oncologist after the initial consulta-
tion to continue his care.

Conclusion
Dentists are faced with disclosing
information to patients about serious
health concerns, as in the case of Tom
Allen’s malignancy. The problems that
face physicians and dentists regarding the
withholding of, or disclosing, information
to the patient are similar. In deference
to Tom’s wife, while a brief delay may be
appropriate, Tom’s medical condition
demands quick action. The dentist’s obli-
gation to disclose the diagnosis is
imperative.

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EDITOR’S COMMENT: Responses to
the ethical dilemmas are views of the
contributors and consultants and not
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34 / OCTOBER 1996