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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January 2003

Texas Dental Journal

The Texas Meeting

133rd Annual Session of the Texas Dental Association

May 1–4, 2003 • San Antonio, Texas
What Would You Do?

Ethical Dilemma #42

Dr. Cindy Markham is a board-certified prosthodontist practicing in a Texas metropolis in an office that she opened four years ago with four other specialists. Dr. Markham is enjoying her best two years of practice and has an excellent referral base. She has also been an expert witness in five dental malpractice cases and has found the experience to be challenging and a way to fulfill her obligation to the profession.

Ms. Jane Arnold is a new patient in her office and she is not a happy with her last dentist. She is 55-years-old and a denture wearer for 20 years. For Jane, wearing dentures was not a shock to her as her parents and two of her sisters were also complete denture wearers in their mid-thirties. Her general health is good with yearly physicals and only mild arthritis in her hands. When asked about her chief complaint, she says, “my lower denture is worthless and is an embarrassment when I talk and eat.”

This is her third set of dentures with the last set made one year ago by a general dentist in her neighborhood. Now she comes to you because she is just “miserable” and saw something on television about dental implants. Her last dentist told her to use more adhesive, grin and bear it. He told her before they started that it would not be easy considering her lack of bone on her lower ridge. Dr. Markham’s preliminary assessment reveals that mandibular implants could be used in the anterior region but bone grafting would be required if any posterior implants are placed.

Ms. Arnold wants to know why she was never informed of implants as an alternative, and if not, if she should ask for her money back. She also said he was a “crook” for taking her money knowing that the denture would never fit — just “grin and bear it,” he said. Finally she asks Dr. Markham, “would you call him and see if he will give my money back?” I can use it to pay you for the implants and dentures.

Dr. Markham is now faced with an ethical dilemma. Check the following course(s) of action she should take in this case and mail, fax this page, e-mail, or send a note indicating your recommendation. What would you do if you were Dr. Markham? Some options (check one or write your own) include:

____ 1. Dr. Markham should call the previous dentist and review the patient's concern;
____ 2. Recommend that Ms. Arnold call the Peer Review group of the local dental society;
____ 3. Dr. Markham should refuse to treat her as she is already a hostile patient and she will probably sue her next;
____ 4. Dr. Markham should volunteer to be an expert witness at her trial;
____ 5. Dr. Markham should plan to place mandibular implants adapting the patient's current mandibular denture if possible;
____ 6. Other alternative (please describe):

SEND YOUR RESPONSE BY November 1, 2002 ATTENTION: Dr. Thomas K. Hasegawa, Jr., Associate Dean for Clinical Services, Baylor College of Dentistry, P.O. Box 660677 Dallas, TX 75266-0677. Fax to (214) 828-8958 or E-mail to thasegawa@tambcd.edu

Texas Dental Journal • October 2002 / 1052
Ethical Dilemma

Dr. Woody is a professor in the Department of Restorative Sciences and Director of
Prosthodontics Residency Program at Baylor College of Dentistry.

“Grin and Bear It” — The Frustrated Denture Wearer Response to Ethical Dilemma #42

Dr. Cindy Markham is a board-certified prosthodontist practicing in a Texas metroplex in an office that she opened 4 years ago with four other specialists. Dr. Markham is enjoying her best 2 years of practice and has an excellent referral base. She has also been an expert witness in five dental malpractice cases and has found the experience to be challenging and a way to fulfill her obligation to the profession.

Ms. Jane Arnold is a new patient in her office and she is not a happy with her last dentist. She is 55-years-old and a denture wearer for 20 years. For Jane, wearing dentures was not a shock to her as her parents and two of her sisters were also complete denture wearers in their mid-thirties. Her general health is good with yearly physicals and only mild arthritis in her hands. When asked about her chief complaint, she says, “my lower denture is worthless and is an embarrassment when I talk and eat.”

This is her third set of dentures with the last set made 1 year ago by a general dentist in her neighborhood. Now she comes to you because she is just “miserable” and saw something on television about dental implants. Her last dentist told her to use more adhesive, grin and bear it. He told her before they started that it would not be easy considering her lack of bone on her lower ridge. Dr. Markham’s preliminary assessment reveals that mandibular implants could be used in the anterior region but bone grafting would be required if any posterior implants are placed.

Ms. Arnold wants to know why she was never informed of implants as an alternative, and if not, if she should ask for her money back. She also said he was a “crook” for taking her money knowing that the denture would never fit — just “grin and bear it,” he said. Finally she asks Dr. Markham, “would you call him and see if he will give my money back?” I can use it to pay for the implants and dentures.

Dentists who responded to the case chose the following alternatives: 1) Dr. Markham should call the previous dentist and review the patient’s concern; 2) Dr. Markham should refuse to treat her as she is already a hostile patient and she will probably sue her next; 3) Dr. Markham should plan to place mandibular implants adapting the patient’s current mandibular denture if possible; and 4) offered other alternatives for this case. None of the respondents chose to have Dr. Markham volunteer to be an expert witness at Ms. Arnold’s trial or that she call the peer review group of the local dental society.

Does Dr. Markham have an obligation to call Ms. Arnold’s previous dentist and ask for a refund? How should he deal with a patient who thinks her previous dentist was a “crook” who allegedly said, “just grin and bear it” as to her ill-fitting dentures? These issues and others provide the background for the following three ethical issues: 1) prosthodontics with/without implants, 2) informed consent/reasonable alternatives, and 3) the search for truth.

Prosthodontics With/Without Implants

Restoration of the completely edentulous mandible has always been one of dentistry’s greatest challenges. Tallgren demonstrated four times greater bone resorption of the mandible compared to the maxilla in a 25-year-long longitudinal study (1). The anatomy, limited osseous support, and active muscle interaction all contribute to the instability of any complete mandibular denture restoration. Despite our best restorative skills, materials, and techniques, the overall long-term result is continued bone resorption and prosthesis instability for the mandibular complete denture. It is not unusual to see pathologic fracture of the mandible due to severe
bone resorption from complete dentures being worn over 20 to 35 years.

In the 1960's Bränemark introduced the concept of osseo-integration with endosseous implants placed anterior between the mental foramina. It was the first implant system to demonstrate a predictable long-term prognosis of 95 percent survival for the mandibular implants at 10 years and beyond (2). Today, many endosseous implant systems are on the market based on similar concepts of osseointegration and showing similar predictable long-term prognosis at 5 and 10 years. Dental endosseous implants have also demonstrated the ability to maintain bone levels and prevent continued excessive bone resorption related to the prosthesis (2).

Treatment of the completely edentulous mandible can be accomplished today with the utilization of implants for support of the prosthesis. Even with advanced mandibular bone resorption, it is often possible to place from two to five implants anterior to the mental foramina. Two implants placed will provide an overdenture concept which may be adapted to an existing complete denture as in Ms. Arnold's case. Placement of four to five implants will give the option of a well-supported overdenture or a fixed detachable (hybrid) restoration.

Today, the standard of care for treatment and restoration of the completely edentulous mandible is becoming the implant supported or implant retained mandibular prosthesis. This allows maintenance of bone levels, stability, restoration of function and esthetics and increase quality of life for our patients with predictable long-term prognosis (3).

Informed Consent/Reasonable Alternatives

"If two dentists consult on a case you will get three opinions." The observation is not a new one: What is there about dental practice that accounts for this perceived variance? Two factors are key including: 1) multiple treatment modalities, and 2) reasonable alternatives in treatment planning.

Each dentist makes clinical judgments based on his or her training, experience, philosophy of practice, and a host of other factors. The author, Sadowsky proposes the concept of moral dilemma of multiple treatment modalities in dentistry (4). Dental patients are routinely offered choices of materials and treatment options such as amalgam versus composite resin, fixed versus removable prosthodontics and removable prosthodontics with and without dental implant support. The author contends that the moral dilemma is that the dentist may view himself or herself as a salesman selling goods of different qualities and costs rather than offering only the best treatment for the patient. Another view here is that there may be viable issues of informed consent due to reasonable alternatives.

The ADA Code under the section of the principle of patient autonomy states: "The dentist shall inform the patient of the proposed treatment, and any reasonable alternatives, in a manner that allows the patient to become involved in treatment decisions (5)." The philosopher Haavi Moreim has observed that, "medicine is inherently uncertain and fallible" and therefore good physicians disagree (6). In this case, Ms. Arnold's previous dentist informed her before she started that it would not be easy with her lack of bone on the lower ridge. Ms. Arnold could have chosen not to start the denture. There is not one standard of care regarding the treatment of patients requiring a mandibular complete denture. Ms. Arnold's previous dentist may have been performed her mandibular denture within the standard of care.

While good clinicians may disagree about the proper treatment for a patient like Ms. Arnold, what is Dr. Markham's obligation to call the previous dentist for a refund?

The Search for Truth

One of the real challenges for every dentist is the patient who is dissatisfied with his or her previous care. Unless the patient is a referral from another dentist, how is the clinician able to know if the patient is being truthful? Should Dr. Markham assume that Ms. Arnold is truthful or give her previous dentist the benefit of the doubt?

Truthful communication, or veracity as cited by the ADA Code, is core to a successful dentist-patient relationship (5). Dr. Markham in this case expects Ms. Arnold to be honest when communicating her health history and her current symptoms, or his care may be inappropriate and may even harm her. Ms. Arnold expects that Dr. Markham will communicate truthfully and, for example, not recommend care that is unnecessary or below the standard of care (5).

Clinicians questioned the veracity of the patient in this case. One dentist said, "Patients often do not tell the truth as to their interactions with other dentists." There is no confirmation for Ms. Arnold's claims and we are not sure whether her clinician offered implants as an alternative or that the patient was told to "grin and bear it." Another dentist noted that, "Dr. Markham has nothing to gain by trying to defend the previous dentist or agreeing with Ms. Arnold's allegations. It is much wiser to not respond to the patients' comments or simply say, if pressed, 'I don't have enough information to form or give an accurate evaluation.' Dr. Markham is under no obligation to pass judgment on her past dentistry."

Do dentists have an obligation to settle disputes between the patient and his or her previous dentist? What role should the dentist play — mediator, advocate for the profession, patient advocate, expert witness, or disinterested clinician? Is Dr. Markham obligated to fulfill the requests of Ms. Arnold simply because she demands this?

The philosopher David Ozar describes various models of the den-
tist-patient relationship which may be helpful here (7). One is called the agent model, where the patient is the decision-maker and the clinician fulfills the decisions. Ms. Arnold is asking Dr. Markham to be her agent and to contact the previous dentist and ask that he return her money. The dentist as agent relinquishes his or her professional judgment, responsibilities and obligations in order to follow the patient's demands, whether or not they are congruent with standards of care. Ozar finds the agent model, with its serious limitations, to be untenable as a proper model for dentistry. The agent model sets aside the idea, "that each profession has certain central values that is committed to fostering, by use of its expertise, for its clients (5)."

A second interactive model acknowledges that both the patient and the clinician bring their values to the treatment setting, and that each should be respected. They are, according to the model, equal partners in this relationship because each has a set of values, makes choices, and only through mutual cooperation bring a full understanding of how these values contribute to the patient's health. The dentist and patient have equal moral standing within this relationship. Ozar explains this as follows:

"But their equality, their equal claim to voice and vote within their relationship, derives from different grounds on the two sides. It derives from the value of autonomy and the fact that it is the patient's body and life that are being affected, on the patient's side, and from the fact of expertise regarding the patient's needs and enabling the patient to regain or maximize control over his or her body and life, which is precisely expertise concerning the central values of dental practice, on the dentist's side. In the Interactive Model both parties have unique and irreplaceable contributions to make in their judgments and choices together, and both the patient's and dentist's values serve as determinants of what they do together (7)."

This means that Dr. Markham respects Ms. Arnold's requests but does not necessarily need to comply with them. The first step would be educating Ms. Arnold so that she can know more about the difficulties of her oral health and function and what opportunities exist to make improvements. Dr. Markham should perform the examination, gather information and formulate a treatment plan. In this regard, one dentist said, "Frequently as a prosthodontist, a good portion of my time is absorbed by trying to make a patient's expectations commensurate with the conditions they present and my abilities." This dialogue is core to establishing a common ground with the patient like Ms. Arnold. A dentist said, "Patients still have their preconceived notions and it is almost impossible to dispel those notions in spite of proper pre-treatment counseling."

One dentist said that calling the previous dentist for a refund was "unethical" and that it is best to "give our colleagues the benefit of the doubt." Also that, "As long as there is a human component to any endeavor, imperfections will always be there and neither the dentist or patient should be presumed to be perfect or at fault for prosthetics falling short of expectations."

**Conclusion**

Good clinicians may disagree about treatment alternatives. Ms. Arnold agreed to have her dentures remade by her previous dentist understanding that her lack of bone on the lower ridge was a risk. While Ms. Arnold is not required to "grin and bear it," Dr. Markham is not obligated to call the previous dentist to request a refund.

**References**


**EDITOR'S COMMENT:**

Responses to the ethical dilemmas are views of the contributors and consultants and not Baylor College of Dentistry, the Institute for Policy Innovation, or the Texas Dental Association. This is not to be taken as legal advice. If you have legal questions, seek competent legal counsel. Address your comments to Dr. Thomas K. Hasegawa, Jr., Office of Clinical Services, Baylor College of Dentistry. P.O. Box 660677, Dallas, TX 75266-0677, Fax to 214 828-8958, or E-mail to thasegawa@tambcd.edu.

**NOTE:** Readers are invited to submit topics to be considered in the Ethical Dilemma column. Contact the editor with suggestions or for further information.