Errata for Dilemma 31

The Pathology Report on page 48 should refer to patient "Don Allen," not "Tom Allen."

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

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Support

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What Would You Do?

Ethical Dilemma #31

Mr. Don Allen is a new patient in your general practice who admits to 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. Don 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.

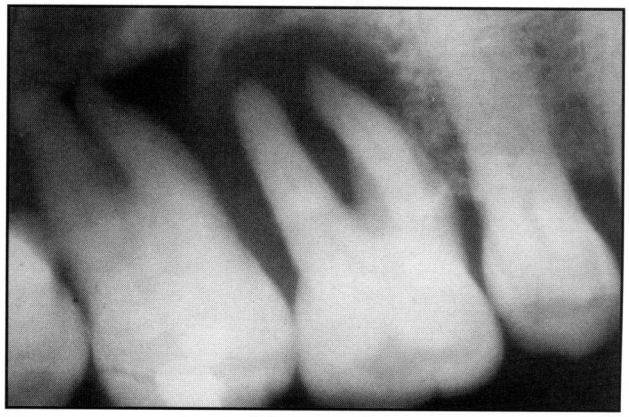

Figure 1

Your examination reveals firmness of the lymph nodes in the left neck, but the nodes are not tender. Intraorally, all of 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 (Figure 1) 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.

Don 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 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. _____ inform Don that you suspect that it is cancer and recommend a biopsy;
2. _____ tell Don that it appears to be suspicious, but that a biopsy is necessary to rule out cancer;
3. _____ just tell Don that you don't know what it is, but that you will refer him to a specialist;
4. _____ since you do not have any personal experience with oral cancer and your suspicion may be wrong, you reappoint Don to reevaluate the lesion in a month or two;
5. _____ tell him that you don't think it is cancer, but that you should biopsy it anyway;
6. _____ try and educate him about the need for a biopsy and the possible complication; or
7. _____ other alternative (please describe):_____

_____.

SEND YOUR RESPONSE BY **June 7, 1996** ATTENTION:
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"Is it cancer?"

Response to Ethical Dilemma #31

Mr. Don Allen is a new patient in your general practice who admits to 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. Don 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 side of the neck, but the nodes are not tender. Intraorally, all of the soft tissues appear within normal limits, except for the gingiva on the mandibular left. In the area of the first molar, there is a raised, somewhat papillary red and white irregular lesion of lx2 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 (Figure 1) 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.

Don 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 asks, "Tell me, is this cancer? I don't know what I will do if it is cancer!"

The majority of the dentists who responded to the case said they would: 1) tell Don that it appears to be suspicious, but that a biopsy is necessary to rule out cancer; or 2) just tell Don that you don't know what it is, but that you will refer him to a specialist. Dentists rarely selected the options: 1) tell him that you don't think it is cancer, but that you should biopsy it anyway; and 2) try and educate him about the need for a biopsy and the possible complications. **None** of the respondents choose to: 1) in-

TDA Council on Ethics and Judicial Affairs

By Thomas K. Hasegawa, Jr., D.D.S.
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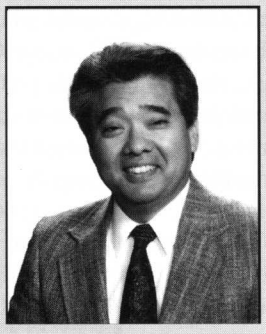

Hasegawa

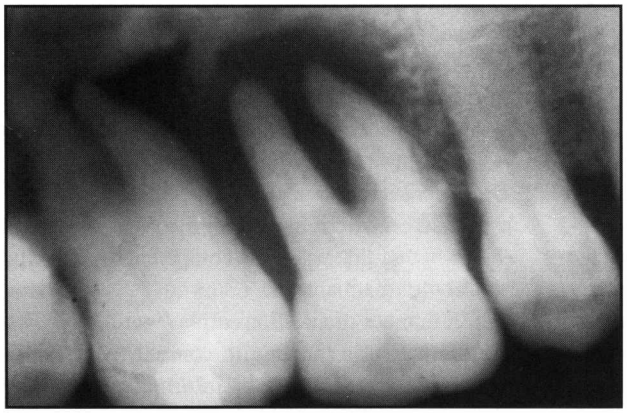

Figure 1

form Don that you suspect that it is cancer and recommend a biopsy; or 2) since you do not have any personal experience with oral cancer and your suspicion may be wrong, you reappoint Don to reevaluate the lesion in a month or two.

What is the dentist's obligation to answer questions from fearful patients like Don? Should we answer these questions honestly, create a positive, but false spin, or defer answering the question? Core ethical issues in this case include: 1) to tell or not to tell; 2) assessing the state of the patient; and 3) veracity in light of incomplete knowledge.

To Tell or Not to Tell

To tell or not tell the truth are choices we make in our daily personal and professional lives. On the personal side, would you answer Don Allen, the neighbor, truthfully if he asks, "Do you think I am a workaholic who smokes and drinks too much?" Would you even volunteer these views to Don? We view the person who is compulsively honest as insensitive, a social misfit, and even a "loose-cannon" in the workplace. What then, are the possible sources of the obligation to tell the truth in social settings?

Philosophers' generally understand truth-telling to be a virtue, obligation or principle, commonly referred to as **veracity**. Philosopher Kate Brown attributes our desire for telling the truth to many sources, including, "respecting others, avoiding coercion and manipulation, supporting community, maintaining reciprocity in relationships, supporting the value of communication generally, eliminating the costs and complexities of deception, refraining from unduly assuming responsibility, and maintaining trust (1)."

While philosophers may agree that most people recognize an obligation to tell the truth, they do not agree that there is one common source of this obligation. A number of possible sources have been proposed, including: religious obligation (e.g., divine commands), or the Golden Rule (e.g., do unto others as you would have them do unto you), or respect for persons (e.g., to respect a person as an independent, choosing agent requires truthfulness) (2).

To tell or not tell the truth to patients is a uniquely different issue. Patients expect their health care professionals to value veracity not as a mere courtesy or matter of etiquette, but an expectation in the doctor-patient relationship. Patients also expect that their care givers will have the patients' benefit or best interests as a priority (3).

A central feature of this case asks, "Does Don really want to know the truth?" because of his fear of oral cancer as a result of his father's experience.

Assessing the State of the Patient

Dentists are not psychiatrists, yet they must make a determination for every patient whether that patient is competent to consent to treatment.

A number of questions arise regarding the patient's capacity to consent. Is Don able to *understand* the information about his condition and is he capable of *communicating* this understanding to the dentist? Does Don have *stable goals and values*, and is he able to make independent decisions using the skills of *reasoning and deliberation (4)*? These are complex questions commonly cited in the consent literature.

Another way a dentist could assess the state of the patient would be to set a sliding scale of 1 to 10, with the number 1 representing the patient who would be emotionally unable to receive any information, and 10 the disinterested patient who does not want to know or even care about his condition — he or she just says to "do it." It is entirely possible that a patient at one on the scale would quickly discontinue treatment or leave the practice. Such devastating news might even prompt suicidal tendencies. For patients in the one to five half of the scale, the dentist may use extra caution to carefully present information without exacerbating fears and phobias. Does this mean the dentist may be deceptive with the patient? As many dentists noted, they would inform the patient that "it appears suspicious, but a biopsy is necessary to rule out cancer." None of the dentists chose to tell Don they did not think it is cancer, but they would recommend a biopsy anyway.

None of the dentists chose to volunteer the information that the lesion, from what they remembered from dental school five years ago, appeared to be malignant. That information could precipitate a fearful response from any person on the scale. It would also be a questionable practice from what we do not know about this lesion.

Veracity in the Light of Incomplete Knowledge

The central question in Don's case is how much of the "truth" about Don's condition is verifiable without a biopsy. When Don asks, "Is it cancer?", he is requesting information about a potentially life-threatening condition. The majority of dentists in this case chose to either tell Don that the lesion appears to be suspicious and recommend a biopsy, or that they just do not know and recommend him to a specialist. One dentist recommended, "Don't lie to him, but don't overly frighten him — act concerned but as if it is a routine matter." A few dentists chose to tell Don about the link between smoking and cancer, while another chose to tell him that cancer is very uncommon and give him other non-cancerous possibilities, such as periodontal disease, even though the dentist suspected cancer. Most dentists said they would inform Don that he needs a biopsy, with several noting a referral to an OMFS. From the information presented in the case, even if the dentist believed that the lesion was malignant, it would be impossible to confirm the diagnosis without a biopsy.

Conclusion

Veracity, or truth-telling, is a core value in the doctor-patient relationship and is central to our understanding of informed consent. There are situations where telling the truth may directly conflict with what the dentist thinks is in the patient's best interest. Don's oral cancer phobia due to his father's malignancy requires extra caution in presenting information. To offer false hope by telling the patient it is probably a periodontal flare up, or a pessimistic outlook by saying it is probably malignant, is inappropriate. Don's question, "Is it cancer?" — requires a truthful but cautious response — the lesion appears to be suspicious and a biopsy is required to establish the diagnosis. The dentist is justified in refraining from revealing information that may exacerbate the patient's fears when dealing with situations of incomplete knowledge. **(NOTE: Don Allen's case will be continued in case #33, What Would You Do?)**

References

1. Brown, KH. Attitudes toward truth-telling. In: Reich WT, ed. Encyclopedia of bioethics. New York: Simon & Schuster MacMillan, 1995:1221-1232.
2. Paternalistic deception, lies and non-disclosure. In: Childress JF, ed. Who should decide? Paternalism in health care. New York: Oxford University Press, 1982:131-3.
3. ADA Principles of ethics and code of professional conduct. January, 1996:1. 4. Odom JG, Bowers DF. Informed consent and refusal. In: Weinstein BD, ed. Dental Ethics. Philadelphia: Lea & Febiger, 1993:73-4. ■

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 Wright is the Director of Pathology in the Department of Diagnostic 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 @baylordallas.edu

All names, addresses, phone numbers, and patient information on this report are fictitious

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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: W

Operated by: Dr. Thomas Smith Patient Reg. No.:

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 basiloid 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: Basiloid squamous cell carcinoma.

COMMENT: The basiloid 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

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