



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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The background of the cover is a photograph of a mountain silhouette against a sky filled with orange and red clouds, suggesting a sunset or sunrise. A small cross is visible on the peak of the mountain.

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What Would You Do?

Ethical Dilemma #36

Life has never been better. Patients have been on time this week, collections are the best in 5 years of specialty practice and patients are booked solid through the next 2 weeks. Dr. Ben Ridely has been in endodontic practice in a thriving college town since completing his specialty program 5 years ago. The economy is good and unemployment is the lowest for years. Today is not a good day for Dr. Ridely, however, because he is seeing Mr. Ralph Stanford for his second instrumentation appointment.

Dr. Richard Land referred Ralph for a root canal for an asymptomatic tooth #3 that had a 2mm periapical lesion on the mesial root. The tooth had "flared up 3 years ago" according to Ralph but has not been painful since. Dr. Land placed a porcelain fused to metal fixed partial denture on the tooth 5 years ago. He had reconstructed all of Ralph's posterior teeth in that quadrant and is planning to remake the restoration when the endodontic care is completed.

The first appointment went well. After a thorough history and assessment, Dr. Ridely determined that the tooth was necrotic and initiated access and instrumentation. The concern for Dr. Ridely was not about the endodontic procedure. The concern was with the quality of the margins on two of the restorations. The x-rays confirmed marginal excesses on the distal of #4, while #2 and #5 were fine. Also, Dr. Ridely could probe under the facial margin on #3 that may explain the possibility of leakage resulting in pulpal necrosis.

Dr. Ridely is concerned because Dr. Land is a good friend and the first practitioner to welcome him to town and to refer patients on a regular basis. Actually, Dr. Land is his best referral source. Dr. Land introduced him to the dental society and made him welcome to many social events. Dr. Ridely is concerned because of the last five patients referred by Dr. Land, two had faulty margins for teeth requiring endodontics — restorations placed by Dr. Land.

Ralph has expressed no concerns as he sees Dr. Land routinely for 6 month recall examinations, with x-rays and cleanings as needed. He just figures that this happens and he trusts Dr. Land's explanation. Dr. Ridely wonders if he should talk to Ralph or Dr. Land about his concerns.

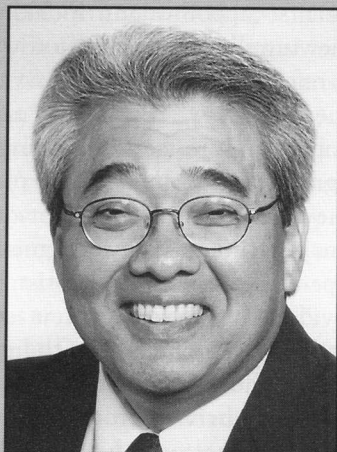
Dr. Ridely is now faced with an ethical dilemma. Check the following course (s) of action he should take in this case and mail, fax this page, Email, or send a note as of your recommendation. What would you do if you were Dr. Ridely? Some options (check one or write your own) include:

- ☐ Dr. Ridely should do nothing — just follow the next few cases to see if there is a pattern to be concerned about;
- ☐ Dr. Ridely should inform Ralph that leakage from the faulty margin on the crown may have contributed to the resulting necrosis of the pulp of the tooth;
- ☐ Dr. Ridely should consult a trusted colleague to help think things through.
- ☐ Dr. Ridely should call Dr. Land and schedule a time to review cases and inform him of the concerns;
- ☐ Dr. Ridely should call the local Dental Society Judicial Council and express his concerns;
- ☐ Other alternative (please describe):

SEND YOUR RESPONSE BY May 1, 2001 ATTENTION: Dr. Thomas K. Hasegawa, Jr.,
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Ethical Dilemma

By Thomas K. Hasegawa, Jr. D.D.S., M.A., Merrill Matthews, Jr. Ph.D. Bruce Peltier, Ph.D. and David Witherspoon, BDSc, MS, BEcon. Dr. Peltier is an Associate Professor in the Department of Dental Practice and Director of Ethics Education at the University of Pacific School of Dentistry. Dr. Witherspoon is an Assistant Professor in the Department of Restorative Sciences at Baylor College of Dentistry.



Hasegawa

The Endodontist's Painful Dilemma

Response to Ethical Dilemma #36

Life has never been better. Patients have been on time this week, collections are the best in 5 years of specialty practice, and patients are booked solid through the next 2 weeks. Dr. Ben Ridely has been in endodontic practice in a thriving college town since completing his specialty program 5 years ago. The economy is good and unemployment is the lowest for years. Today is not a good day for Dr. Ridely, however, because he is seeing Mr. Ralph Stanford for his second instrumentation appointment.

Dr. Richard Land referred Ralph for a root canal for an asymptomatic tooth #3 that had a 2mm periradicular lesion on the mesial root. The tooth had "flared up 3 years ago" according to Ralph, but has not been painful since. Dr. Land placed a porcelain fused to metal fixed partial denture on the tooth 5 years ago. He had reconstructed all of Ralph's posterior teeth in that quadrant and is planning to remake the restoration when the endodontic care is completed.

The first appointment went well. After a thorough history and assessment, Dr. Ridely diagnosed #3 as having pulpal necrosis with chronic periradicular periodontitis

and subsequently initiated treatment. The concern for Dr. Ridely was not about the endodontic procedure. The concern was with the quality of the margins on two of the restorations. The x-rays confirmed marginal excesses on the distal of #4, while #2 and #5 were fine. Also, Dr. Ridely could probe under the facial margin on #3, and that may explain the possibility of leakage resulting in pulpal necrosis.

Dr. Ridely is concerned because Dr. Land is a good friend and the first practitioner to welcome him to town and to refer patients on a regular basis. Actually, Dr. Land is his best referral source. Dr. Land introduced him to the dental society and made him welcome to many social events. Dr. Ridely is concerned because of the last five patients referred by Dr. Land, two had faulty margins for teeth requiring endodontics — restorations placed by Dr. Land.

Ralph has expressed no concerns as he sees Dr. Land routinely for 6 month recall examinations, with x-rays and cleanings as needed. He just figures that this happens and he trusts Dr. Land's explanation. Dr. Ridely wonders if he should talk to Ralph or Dr. Land about his concerns.

Dentists who responded to the case chose four of the five alternatives, offered general advice and cited specific incidences of similar concerns in their own practices. The four alternatives include: 1)

E t h i c a l

Dr. Ridely should do nothing — just follow the next few cases to see if there is a pattern to be concerned about; 2) Dr. Ridely should inform Ralph that leakage from the faulty margin on the crown may have contributed to the resulting necrosis of the pulp of the tooth; 3) Dr. Ridely should call Dr. Land and schedule a time to review cases and inform him of the concerns; and 4) Dr. Ridely should consult a trusted colleague to help think things through. None of the respondents chose to have Dr. Ridely call the local Dental Society Judicial Council and express his concerns.

Most of the dentists expressed that Dr. Ridely has a responsibility to the referring dentist, Dr. Land, to inform him of the concerns in this case. One dentist wrote that Dr. Ridely had no way of knowing the conditions under which the dentistry was placed, how it was cared for, when it was done, or if it was actually performed by that dentist. Another wrote that in 21 years of practice he/she had noted that some dentists were “very quick to judge other members” and that “it is really tragic that this attitude exists.” Should endodontists share these concerns with their referring dentists? The ethical concerns in this case include: 1) the unique aspects of endodontic practice; 2) the endodontist — technician or professional; and 3) the endodontist's duty.

Unique Aspects of Endodontic Practice

Before endodontics was recognized as a dental speciality in 1963, all root canals were treated by general dentists (1). The majority of root canal therapy today is still provided by general dentists. The edu-

cation and training of the endodontist along with the improvements in materials, equipment and treatment modalities has improved the quality of care to our patients. There are certain unique characteristics of this speciality that are relevant to this case including: 1) pain relief; 2) a trusting doctor-patient relationship; 3) a trusting doctor-doctor relationship; and 4) referral patterns.

The relief of pain is a distinctive feature of the speciality of endodontics. In medicine, pain relief is considered a duty or obligation; that is one that is expected of the doctor. The purpose of the patient visit to the doctor is “to be healed, to be restored and made whole (2).” Removing harmful conditions is part of endodontic practice whether by treating an irreversible pulpitis, acute periradicular periodontitis, or an alveolar abscess resulting from pulpal necrosis (3). These painful, noxious conditions affect the patient's quality of life and delaying care may have serious consequences to his/her oral, and even general health (4).

The first appointment for the endodontist is often an emergency visit with the patient requiring immediate attention. As one author writes, “No dentist should need reminding that an endodontic emergency has never been an elective visit for the patient in pain (5).” This is distinctly different from the first visit to the orthodontist, periodontist, or prosthodontist (1). The closest parallel would be the oral surgeon's practice where there would be a mixture of referral patients with some requiring emergency care. The emergency endodontic patient may be on edge due to acute symptoms and extreme discomfort. These elements add to

the diagnostic challenge and dynamics of the first visit. The clinician must be prepared to deal with the myriad of complexities of emergency practice and to deal effectively and expeditiously with pain and infection.

A great deal must occur during this first appointment including: reviewing the communication with the referring dentist, gathering the patient history, diagnostic radiographs and tests, formulating a diagnosis and treatment plan, reviewing informed consent and securing financial arrangements. Hopefully the general dentist has provided the patient with a substantive background as to the purpose of the referral and what to expect on arrival. From this and other information, the endodontist must decide if the patient is properly informed and prepared for treatment.

A second unique aspect is that patient care is episodic and typically only a few appointments in length. Is it possible to establish a trusting doctor-patient relationship within these few appointments? The patient may arrive at the endodontist's office with a preconceived, overwhelming fear of the “dreaded root canal.” After all, in our culture, going to the dentist and having a root canal can be a painful experience. The patient may be in such acute pain that he/she is unable to make normal, rational judgments. The endodontist, unfortunately, must assess in this brief encounter if the patient's acute pain is authentic or the feigned symptoms of the drug-seeker. Will this patient even return for the second appointment?

Dr. Ridely may know from experience that he can trust Dr.

Dilemma

Land's referrals but must be wary about those from certain other practices. Some referrals may not inform the patient of the costs, pre-existing conditions (i.e. separated instruments or perforations), or risks of complications. This may cause a breakdown in trust between the general dentist and the specialist.

Finally, the endodontist relies heavily on referring clinicians to maintain an active practice (1). Dr. Land is Dr. Ridely's good friend and best referral source. Will Dr. Ridely jeopardize this relationship by discussing his concerns for the quality of margins on two of the last five cases referred by Dr. Land? Or should Dr. Land expect Dr. Ridely to share these concerns as no clinician can be expected to provide flawless care?

Endodontist — Technician or Professional?

The endodontist's concerns and obligations are more than technical. Certainly there is the technical side — that is, providing the most contemporary, competent care for the benefit of the patient (6). Clinicians, whether generalists or specialists as in this case, must make a variety of decisions. How will the outcomes of my treatment effect the quality of care overall for the patient? Is the tooth restorable? Are there periodontal concerns? Should I place a temporary restoration or definitive build-up? Should this patient be treated at all? These types of assessments cannot be made in isolation. If we prioritize the importance of the patient's general health and appropriate oral function, we know that decisions made by the specialist must be determined within the dialogue among the generalist, the specialist and the patient.

This dialogue is a central feature of this case and a just expectation of the professional. The generalist, just as the patient, needs to know what to expect from the endodontist. The endodontist must know the overall plan for the patient to assure that he/she is providing the right treatment for the right patient. Without this dialogue the situation is ripe for misunderstandings and failed expectations. The endodontist should carefully convey informed consent to the patient. Prognosis is core to this discussion as the relative difficulty of the planned care must be assessed along with the risks of failure. Patients may read in a consent form; "All dental procedures may involve risks for unsuccessful results and complications, and no guarantee is made as to result or cure (7)." Even with the most thorough informed consent the patient may still assume that unsuccessful results or complications are the result of substandard work and expect refunds, free or reduced fees. Proper communication allows the patient to make the decision whether the benefits and risks of treatment, including the risks of additional procedures and costs, are worth taking.

Most of the clinicians expressed that Dr. Ridely has a responsibility to the referring dentist, Dr. Land, to inform him of the concerns in this case. One person wrote that "discretion in these instances is incredibly important" and that some dentists think there is only one "right way and everyone else is wrong." Also that this scenario between Dr. Ridely and Dr. Land is "many times handled poorly, and ends up a lose-lose situation." An endodontist wrote that "Dr. Ridely as a specialist, can write

a letter to Dr. Land, as he should anyway, letting Dr. Land know the patient's treatment has begun, confirming Dr. Land's tentative diagnosis and adding that during the evaluation, he noticed a 'marginal excess' on tooth #4. That is it. He should not pass judgment or recommend treatment." Another dentist wrote that "Dr. Land should know about the submarginal fit of his crowns, and Dr. Ridely should help him." This act will "only save Dr. Land from legal or Board problems, so it is an issue that should be faced as soon as possible."

Are there ways for Dr. Ridely to communicate these concerns to Dr. Land avoiding the "lose-lose" outcome?

The Endodontist's Duty

Many doctors and ethicists would strongly recommend that Dr. Land be informed about the status of restorations that he has placed. The most important reason is not to protect Dr. Land (which is a good reason), but to protect present and future patients of Dr. Land. Doctors are expected to "above all, or first, do no harm" which is the essence of protecting present and future patients (6).

This means that someone has to communicate with Dr. Land about this. The first step is to do a little thinking. Think about how you might like to be approached if you were in Dr. Land's position. (Which of us would prefer not to be told? Most of us would prefer to know, wouldn't we?) Think about Dr. Land. What kind of person is he? Would he prefer a direct conversation with no punches pulled? Would he respond better if the message were wrapped in warm, fuzzy blankets?

Ethical Dilemma

A face-to-face discussion is necessary in this case. You and Dr. Land have a long-standing professional relationship and it seems disrespectful to simply send a letter about such an important and difficult matter. Some guidelines for the communication might include: a) pick the optimal time and place. Don't put it off too long, but also don't blurt it out the first time you run into Dr. Land. Take care of this matter in a private, comfortable setting with the chance for an extended two-way discussion; b) frame the discussion in a positive, non-judgmental, non-punitive way. Use examples of behavioral observations such as, "I noticed that the marginal excess was 2mm in size;" c) sandwich the negative observations between two positive comments about the other doctor or about your long-standing respect or relationship with him or her. End with another positive comment about the future. Offer to help (if that doesn't seem too condescending); d) be prepared for defensiveness and denial. Don't fight that. Perhaps it will be enough to simply plant the idea or to let the doctor know that his work is being noticed; e) use gentle but straightforward language and communicate a concern for Dr. Land:

"In the Stanford case and the Jones case I noticed that the margins were on the large side, and I'm not used to seeing that in the patients you've sent me over the years. I didn't know if you were aware of this. I've wanted to mention it to you because I know how much you care about the quality of your work."

You could also say:

"I hope you don't mind my mentioning these things. I hope that you would talk to me if you had similar concerns about my work, as well."

The meeting could be done in one of (at least) three ways. 1) Set up a meeting specifically for this purpose. One responder called this "a time to review cases." That's straightforward and honest enough. 2) Set up a lunch meeting or a "coffee." Bring your concerns up there. 3) Wait until you are together in a social situation and nudge the conversation around to the issue in question. Or do it on the golf course or on a trip in the car.

Conclusion

Each dental speciality has distinctive qualities that may cause ethical challenges for their clinicians. For endodontics, relieving pain in emergency conditions over a few appointment visits increases the opportunities for conflicts and dilemmas with patients and referring dentists. Specialists depend on referrals and if we are to maintain our professionalism, we owe it to each other and to our patients and profession to talk directly to colleagues about these difficult matters. It is hard to do, but it gets easier each time you do it.

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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 8952, or E-mail to thasegawa@tamcd.edu.