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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.

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# TEXAS DENTAL Journal





# What Would You Do?

## Ethical Dilemma #37

**D**r. Mike Crawford thought to himself, what a busy day! Everyone is on time this morning and we have two emergencies scheduled at 11:00 a.m. Four years ago, just out of dental school and opening the doors to his solo practice, it was not always this busy. Now the debts are getting more under control and the new patient referrals have been very encouraging.

Jane Harper is Dr. Crawford's dental assistant, and at 10:45 a.m. greets Dorothy Simms, the first of two emergency patients, and takes her to the operatory. Dr. Crawford makes a mental note that the patient appears to be limping as if she sprained an ankle as she walks down the hall.

Jane gathers some preliminary information and asks Dorothy what is the nature of her visit. Besides her limping, Dorothy obviously has suffered a facial injury — maybe from a car accident — and has bruises on her left forearm and cheek. Dorothy is a 23-year-old white female who is in good health overall, stable vital signs and has a history of episodic visits to the dentist. Her last visit to the dentist 2 years ago was related to an accident and loss of a tooth. Jane asks Dorothy, "What happened to you?" Dorothy very quietly says, "I fell down." Her face has a pained expression and she has a bruise over her left eye and cheek and her upper lip is swollen. When she is talking, Jane notes that #9 and #10 both have a disto-incisal edge fractures and that she is missing #26.

Dr. Crawford reviews the emergency form with Jane before meeting the patient. Jane suspects that this injury was not an accident but the result of physical abuse and conveys this verbally to Dr. Crawford. He remembers her limp and on meeting Dorothy, is surprised at the extent of the facial injuries. In addition to the current injury, she has at least three other visible scars on her face including a 5mm vertical scar on the vermillion border on the midline of her lower lip. On the medical history form, under the "purpose of the visit today," Dorothy writes, "I slipped and fell in the kitchen and bumped my teeth."

The examination by Dr. Crawford reveals class II mobility of #9, #10 and #11 with disto-incisal edge enamel fractures of #9 and #10. Radiographs reveal no radicular or alveolar fractures. The fractured edges are sharp and he recommends reshaping the edges today since there is no exposed dentin. He will reappoint Dorothy to bond two class IV composite resins.

The larger concern for Dr. Crawford is whether these injuries are accidental or the result of physical abuse. Dr. Crawford says to Dorothy, "Usually falls do not have the appearance that I see today. It appears to me that someone has beaten you." Dorothy then admits that she was struck "several times" by her husband the previous night and that she does not know what to do. Her husband is in the reception room waiting to take her home.

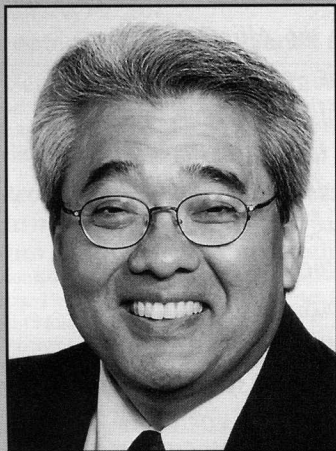
Dr. Crawford is now faced with an ethical dilemma. Check the following course(s) of action he should take in this case and mail or fax this page or send an email or note on your recommendation. What would you do if you were Dr. Crawford? Some options (check one or write your own) include:

- ☐ Dr. Crawford should advise the patient to get help;
- ☐ Dr. Crawford should refer the patient to her physician and then consult on the case;
- ☐ Dr. Crawford should give verbal support to the patient and supply resources/information on shelters and counseling;
- ☐ Dr. Crawford should confront the husband with his suspicions, inform him of the illegality of abuse and encourage him to get help;
- ☐ Dr. Crawford should contact the authorities and report this physical assault immediately;
- ☐ Dr. Crawford should do nothing but document his findings in the progress notes;
- ☐ Other alternative (please describe):

**SEND YOUR RESPONSE BY SEPTEMBER 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., Marylou Gutmann, BSDH, MA.  
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Hasegawa

## Ethical Issues of Domestic Violence

### *Response to Ethical Dilemma #37*

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Dr. Crawford reviews the emergency form with Jane before meeting the patient. Jane suspects that this injury was not an accident but the result of physical abuse and conveys this verbally to Dr. Crawford. He remembers her limp and on meeting Dorothy, is surprised at the extent of the facial injuries. In addition to the current injury, she has at least three other visible scars on her face including a 5mm vertical scar on the vermillion border on the midline of her lower lip. On the medical history form, under the "purpose of the visit today," Dorothy writes, "I slipped and fell in the kitchen and bumped my teeth."

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Dorothy, "Usually falls do not have the appearance that I see today. It appears to me that someone has beaten you." Dorothy then admits that she was struck "several times" by her husband the previous night and that she does not know what to do. Her husband is in the reception room waiting to take her home.

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The dentists who responded to the case recommended three alternatives, including: 1) Dr. Crawford should give verbal support to the patient and supply resources/information on shelters and counseling; 2) Dr. Crawford should contact the authorities and report the physical assault immediately; and 3) a combination of the first two alternatives plus advise the patient to get help and confront her husband with his suspicions. None of the respondents chose to have Dr. Crawford do nothing but document the findings in the progress notes.

Dorothy has confided to Dr. Crawford that she is the victim of domestic violence. What ethical obligations does Dr. Crawford have towards Dorothy now that she has confirmed his suspicions and those of his dental assistant? Should he just smooth the rough enamel edges today and set aside Dorothy's personal concerns? Could Dorothy actually suffer more vicious attacks later, even death, if the dentist confronts her spouse who is waiting in the reception room?

We will address three aspects of domestic violence, including: 1) what are the various signs of abuse that dental professionals should recognize and questions that would help while screening for abuse; 2) what are the ethical obligations to identify and help the victim; and 3) how can dental professionals support the patient effectively?

### **Signs of Abuse**

Domestic violence is defined as abuse by either a current or former intimate partner (1, 2). Because most abuse occurs in the head and neck region, dental health care providers are in an excellent position to help stem the epidemic of domestic abuse by recognizing and documenting suspected abuse in dental patients and providing support to such victims (1, 3-5). Various signs and symptoms of domestic abuse are observable during the normal course of a dental visit. Patients may exhibit a combination of maltreatment, including physical and sexual abuse, emotional or psychological abuse, and economic exploitation (2).

### **Physical Abuse**

The dental practitioner should be suspicious of bilateral injuries, as accidents are usually unilateral (6). Lacerations may involve the face or anywhere within the oral cavity. Other dental injuries that may be observed include: broken or missing teeth, fractured roots or evidence of root tips and discolored teeth (2, 7).

Dorothy had mobile and fractured teeth and evidence of three facial scars from previous injuries.

Bruises and welts on the face, arms or legs, in various stages of healing, should be questioned. For example, Dr. Crawford immediately noted that Dorothy was limping, an important finding in his physical assessment along with bruising on her forearm, over her left eye and cheek. Bruises in unusual patterns might reflect the pattern of the instrument used to inflict the injury (2, 6, 7, 8).

Burns may occur intraorally or on the face, arms or leg (8). Skeletal injuries of the maxilla, mandible or nose may be seen on radiographs (9). Head injuries may be observed as absence of hair or hemorrhaging beneath the scalp due to vigorous hair pulling (10).

When the patient's medical history and interview is unable to offer a reasonable explanation, all physical injuries should be considered indicators of abuse.

### **Sexual, Emotional and Economic Abuse**

Sexual abuse can be observed during a dental exam as an intraoral infection of sexual origin including gonorrhea, condyloma acuminatum (venereal warts), syphilis, herpes, moniliasis, trichomonas, and an erythematous/petechial palate due to forced oral sex (11).

Emotional or psychological abuse takes many forms, including threatening, belittling, humiliation

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and gestures (2). An abused patient may appear to be overly nervous or anxious or passive with a dislike of being touched (1, 12). A victim may also appear overly aggressive, violent or demanding and have dramatic mood changes.

Economic abuse occurs when the perpetrator prevents the victim from getting or keeping a job, keeps the victim on an allowance, takes the victim's money, or not letting the victim know about or have access to family income (2).

## Screening for Abuse

If abuse is suspected, the dental professional's obligation is to confirm the abuse and provide support to the victim (4, 13). Most patients, like Dorothy, do not volunteer information concerning the presence of domestic violence, but in one survey 97 percent of victims wished the healthcare provider would ask about abuse (14). Some patients will talk freely if asked, while some may be too afraid or embarrassed to discuss the subject (15). The health history form should ask about a history of abuse.

The practitioner should discuss the clinical observations and ask the patient about the concerns in a non-judgmental manner (16).

Listening is also a good mechanism for obtaining information and may be therapeutic for the patient. It is less threatening to approach the patient by asking (2):

- How did the injury happen?

- Who was with you when the injury happened?
- Are you afraid of anyone?
- Are you concerned about your safety?
- Do you have a safe place to go with your children?

Assessing safety is a key intervention in domestic violence. Dental personnel should never suggest that the patient leave the perpetrator without a plan because that can be the most dangerous time for a victim and could result in death (13). Instead, give supportive messages, such as (16, 17):

- No one deserves to be hit.
- You are not alone.
- It's a common problem.
- You have other options.

It is advisable to interview the victim and the perpetrator, but not in the same room (17). Assess whether the explanations are the same, and if they are consistent with the injury (9).

A standard procedure for dealing with abuse victims (maltreatment protocol) should be developed for the office. Accurate, concise and comprehensive records should be maintained, including a detailed description of the observations and, if possible, extraoral and intraoral photographs (9, 16, 18).

## Ethical Obligations

Both the ADA Principles of Ethics and the AMA Code of Medical Ethics provide insights

into this matter of professional obligations towards victims of abuse and neglect.

The ADA, in the Preamble to the Principles of Ethics, calls upon dentists to follow high ethical standards that have the "benefit of the patient as their primary goal (19)." Concerns for abuse and neglect of patients are addressed under the principle of beneficence (doing good): "dentists shall be obliged to become familiar with the signs of abuse and neglect and to report suspected cases to the proper authorities, consistent with state laws (19)." This obligation is further defined in the Advisory Opinion: "Dentists have a concurrent ethical obligation to respect an adult patient's right to self-determination and confidentiality and to promote the welfare of all patients. Care should be exercised to respect the wishes of an adult patient who asks that a suspected case of abuse and/or neglect not be reported, where such a report is not mandated by law. With the patient's permission, other possible solutions may be sought." The opinion carefully delineates the complexity of promoting the welfare of the competent adult patient regarding abuse and neglect.

The AMA Code of Medical Ethics states that physicians have an ethical obligation to intervene in cases of mentally competent adult victims of abuse. The Code qualifies this obligation to intervene by stating: "Actions should include but would not be limited to:



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suggesting the possibility of abuse with the adult patient; discussing the safety mechanisms available to the adult patient (e.g. reporting to the police or appropriate state authority); making available to the adult patient a list of community and legal resources; providing ongoing support; and documenting the situation for future reference. Physicians must discuss possible interventions and the problem of family violence with adult patients in privacy and safety (20)."

Both the ADA and AMA Codes defer to the autonomous rights of the competent adult patient as central in this matter of domestic abuse. In Texas, it is required to report suspected child, elder and disabled abuse. However, reporting intimate partner abuse is not required by law due to the autonomy attributed to competent adults (21).

"Autonomy" is a term that is derived from the Greek words *autos* (self) and *nomos* (rule, governance, or law) (22). Under the principle of patient autonomy (self-governance), the dentist has a duty to respect the patient's right to self-determination and confidentiality (19). The autonomous patient is able to determine his/her own course of action according to his/her own goals and constraints. This approach recognizes that autonomy is the basis for informed consent and foundational to the doctor-patient relationship. However, when patients are suffering

harm, deny abuse or even demand that the clinician not get involved, it more difficult to respect these rights.

A third principle, called non-maleficence, is useful here since it is a term associated with the maxim *primum non nocere* — above all, or first, do no harm. Another reason that reporting intimate partner abuse is not required by law in Texas is that reporting the abuse many actually endanger the victim's life (23). The clinician must somehow weigh the relevant factors and decide how he/she can both respect the patient's autonomous rights while also protecting the victim from further harm. In a life-threatening situation, the clinician may decide that the only morally responsible action is to call 911. In Dorothy's case, Dr. Crawford may decide that there are other ways to be supportive.

## Support the Patient

Providing an individual with knowledge and support to obtain help is the goal (13). A list of shelters and telephone numbers should be compiled and available if a patient desires help (20). To obtain a list of shelters, call the Department of Protective Services in the local area. Keep in mind that sometimes it is unsafe for a woman to have this information in her possession (2,13). Referral information should also be available in the rest rooms, as sometimes that is the only place a woman can go without the perpe-

trator being present (13).

Patients are most at risk when leaving an abusive situation (13). It is imperative to understand this fact and refrain from forcing the issue of the patient leaving the abuser until it is safe to do so (17).

Dental offices could provide another type of support to an abuse victim by providing free or reduced fees for dental care. Many victims of abuse have lost anterior teeth and do not have sufficient funds to have needed work done. Donating professional services could help to restore a victim's self-esteem or facilitate re-entry into the job market.

## Conclusion

Ethical obligations to our patients extend beyond the treatment of the symptoms of domestic violence. To protect the safety of the patient, all dental staff should attend continuing education courses to assist in the recognition, screening, documentation and support of victims of domestic violence. By taking an active role and not waiting for someone else to take the lead, every dental practitioner could be instrumental in saving a life or improving the quality of life for an individual like Dorothy in their care.

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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@tambcd.edu.