Risk management in clinical practice. Part 2. Getting to 'yes' – the matter of consent

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IN BRIEF

- Consent is a process not a one-off event and the changing nature of a course of treatment must be communicated to the patient.
- As part of obtaining consent, the patient must have adequate knowledge about the particular dental procedure they are invited to undergo.
- Written consent is important but cannot be considered a substitute for obtaining valid consent.

Consent is an integral part of delivering the care patients want. In order to consent to treatment, patients must have the legal capacity to give valid consent. If this three stage test is satisfied, the patient can elect to have any treatment they wish even if it is not in their best interest. Before a patient is able to consent to treatment they must have adequate knowledge about the risks, benefits and alternatives to the treatment. The amount of information provided to the patient by the dentist is determined to some degree by the legal system prevailing. The patient must voluntarily agree to treatment without being coerced by the dentist or other parties and if things change during treatment the patient needs to be advised. Written consent is very useful in the defence of cases but simply signing the consent form does not mean that the patient knows or understands the treatment to which they have agreed.

General dental practitioners provide the vast majority of dental care to the public in most countries across the world. In the UK a registered dentist, whether they have qualified in the UK or not, is legally qualified to provide a whole range of

dental treatment as defined by the General Dental Council (GDC).¹ Foremost among these treatments are the clinical disciplines including restorative dentistry, preventive dentistry, child dental health, oral medicine, oral surgery and oral pathology, pain and anxiety control and dental radiology.

As the GDC point out, 'the practice of dentistry demands that practitioners accept a wide variety of responsibilities ranging from health promotion through to illness prevention, diagnosis and treatment. The safety of patients depends on high ethical standards and on the judgement and skills – both clinical and interpersonal – of the practitioner.'

All the different disciplines, on their own or in combination with each other, can be utilised to provide dental care for patients and the determining factor for their use will be their appropriateness for that particular patient, the patient's agreement to receive them and the dentist's competence to provide them. There are of course many other components to the successful treatment planning and delivery of care to a patient and whilst these determining factors seem on the face of it to be simplistic, they come enmeshed with a whole host of underpinning principles.

The appropriateness of the treatment in general dental practice, in a dento-legal sense, will be judged by the standards

adopted by fellow general dental practitioners. The patient's agreement to the treatment is an integral part of the consent process and the dentist's competence to provide it is a heady mix of self appraisal and insight, professionalism and ethics. Simply put, a dentist should be working within their comfort zone but it is sometimes when their comfort zone is wider than their competence zone that problems arise.

Dentists are in the business of trying to deliver appropriate and acceptable outcomes for their patients and this concept of acceptability is the very essence of the process by which dentists and patients work together to achieve certain agreed outcomes. This article is about getting the patient's agreement to proceed along a certain path of treatment. In the treatment planning process it is important to recognise that all treatment interventions have consequences and while the starting point of a particular treatment may be the same, the end point will not be, depending on which route is taken. While we may well deliver treatment in courses or phases, whenever the patient ends up having had interventional treatment they will always be on another cycle for future treatment.

Some would argue that the best dentistry is no dentistry or preventive dentistry, since all other interventional dentistry, whether it is needed to treat disease or to

RISK MANAGEMENT IN CLINICAL PRACTICE

1. Introduction
2. **Getting to 'yes' – the matter of consent**
3. Crowns and bridges
4. Endodontics
5. Ethical considerations for dental enhancement procedures
- 6a. Identifying and avoiding medico-legal risks in complete denture prosthetics
- 6b. Identifying and avoiding medico-legal risks in removable dentures
7. Dento-legal aspects of orthodontic practice
8. Temporomandibular disorders
9. Dental implants
10. Periodontology
11. Oral surgery

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satisfy a particular demand that a patient has, will have consequences. This is the start of the consent process in general dental practice. The treatment planning process is set out in many excellent books aimed at both generalists and specialists. The broad principles, however, are the same and are often outlined as a series of steps, or a cycle, where the review or reassessment of treatment feeds back into examination and diagnosis:

- Examination and history
- Special tests
- Diagnosis
- Treatment options and discussion
- Treatment plan
- Treatment
- Review.

Donabedian's approach to quality assessment examines the familiar triad of structure, process and outcome.² Claims and complaints are outcomes to a process and part of understanding how the problems arose in any risk management model is to examine the environment in which the treatment was provided (structure) and then analyse the delivery of that care to establish how the sub-optimal outcome came about.

One of the root causes of many problems in dentistry is the failure of communication between the clinician and patient which is an essential part of the consent process. When the patient says 'If only the dentist had told me, I would not have gone ahead' or 'Why didn't the dentist tell me something had not gone according to plan, at least I would have known', you know there are issues of consent at the heart of the problem.

WHAT EXACTLY IS CONSENT?

Consent is the voluntary and continuing permission of the patient to receive particular treatments and must be given by a patient who has capacity to consent to the intervention in question. It must be based upon adequate knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success, and a discussion of any alternative to it. To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the patient either to accept or refuse treatment.

Consent is a process, not a one-off event.³ Before a patient can give valid consent to dental treatment, they must be deemed in law to possess the required capacity. Every person is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted.⁴ This is further emphasised by the basic principles set out in the Mental Capacity Act 2005.

A three stage test⁵ of capacity is that once given information, the patient:

1. Can understand and retain the information given
2. Believes it
3. Is able to weigh that information and balance the risk against the advantages and make a decision.

It is a fundamental principle of self determination that if an adult of sound mind refuses, however unreasonably, to consent to a course of dental treatment offered, the dental team must allow them to make that decision even if they do not consider it to be in his or her best interests to do so. A patient, therefore, who insists on having a tooth extracted against your advice or who refuses antibiotics when it is clearly indicated, has the right to do so. Your responsibility is to note down the options and advice you have given in your records, confirming what the consequences might be for any decision made by the patient. Remember, 'even when his or her life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it.'⁶ A recent case confirmed that where capacity is not an issue, 'the wishes of the patient *have* to be respected by doctors irrespective of the outcome' (author's italics).⁷

There is no obligation on a dentist to provide treatment against their better judgement. Where elective treatment is concerned, while a dentist may be competent to carry out the procedure and the patient has given valid consent, the dentist does not have to carry out the treatment. In such cases the patient must be advised accordingly and a referral offered. This may occur for example when a patient requests crowns for several unrestored teeth for cosmetic purposes and the dentist advises orthodontic treatment instead.

Let us go back to the definition of consent given in bold above and examine some further aspects of consent.

KNOWLEDGE

The essential component of the knowledge element is how much information a patient needs to know about a particular dental procedure in order for consent to be valid and, therefore, defensible either in any legal action or before the GDC.⁸ The leading case that demonstrates this principle in English law is the Sidaway case.⁹ In this case, the House of Lords decided that the legal standard to be applied in assessing whether a clinician was negligent in relation to the provision of advice about treatment was that contained in the Bolam test:¹⁰ a dentist would not be guilty of negligence if he or she had acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.¹¹

Simply put, if it is not usual practice to warn about something, for example the loss of vitality when preparing a tooth for a crown, then failure to do so would not amount to negligence.

This principle, however, is modified by two quite important considerations. The first relates to the Bolitho case.¹² In this case there were two schools of opinion as to what was judged to be the best management of two-year-old Patrick Bolitho when he was admitted to hospital suffering from croup. It revolved around the timing of intubation but in coming to a conclusion, the House of Lords judges indicated that whilst an opinion may be responsible, reasonable and respectable, if it did not stand up to logic then it should not be accepted.

The second consideration is the concept not of what a reasonable dentist may wish to advise a patient about a particular treatment, but what a reasonable patient might wish to hear. This has been played out in the Australian legal system¹³ and has also become part of English common law.

In the Pearce case, the Court of Appeal applied the reasonable patient standard, saying 'If there is a significant risk which would affect the judgment of the reasonable patient, then in the normal course it the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for him or herself as to what course he or she should adopt.'¹⁴

The concept of the reasonable patient is already part of the GDC mindset: 'Find out

what your patients want to know, as well as telling them what you think they need to know.³ This is a very patient-centred approach and creates a significantly higher burden on the dentist to provide appropriate information with which the patient can make decisions. This means that giving the 'usual warnings' about a particular procedure may not be sufficient if a patient is likely to attach more significance to one particular risk than another.

A young professional flute player, for example, may be more concerned about lingual or mental nerve damage from a surgical procedure than a middle-aged building site labourer, and therefore the emphasis you place on the various risks a procedure entails may well have to be modified according to the patient sitting in your chair. You might well conclude that as there is no law or guideline that describes exactly how a reasonable patient should be informed about possible risk, providing them with information is like playing Russian roulette.¹⁵ In later parts of this series we will look at what risks are common in the various specialties and what would be considered to be appropriate warnings that the reasonable or prudent patient should receive.

The judgement in *Afshar v Chester*¹⁶ appears to take the requirement to provide information to patients one step further. In this case, determined by the House of Lords, Miss Chester underwent a spinal operation which carried an inherent 1-2% risk of cauda equine syndrome, which results in paraplegia. The surgery was not negligently carried out but unfortunately the outcome of the surgery was cauda equine syndrome.

It was established that the surgeon failed to warn the patient of the risks of the operation. However, even though she agreed she might still have gone ahead with the operation with the same surgeon, perhaps at a different time, and the risk was not increased nor the chance of avoiding it lessened by what Dr Afshar failed to do, the House of Lords determined, in a judgment of three judges to two dissenting, that this failure to provide information on the risks violated the patient's right to choose. Essentially then, in order for a patient's right to autonomy to be preserved, they must be given all the relevant information to enable them to determine what is right for them.

There is some evidence that the way in which information is presented by clinicians produces different treatment acceptance by patients and this is particularly the case when conveying the risks of certain procedures. Most patients prefer numerical risk information¹⁷ and do not find terms such as 'usually', 'infrequent', 'rare' or 'some' as helpful in providing risk information. Since everyone will interpret words in different ways, using expressions such as 'high risk' or 'moderate risk' will not be useful.

It is important to recognise that patients will not always remember important facts about their treatment and it is incumbent on clinicians to put this information across in the most accessible format, be it in the form of written text, diagrams, DVDs or audio tapes. Even when some effects or risks are irreversible, only a small percentage of patients recall the risks.¹⁸

This knowledge about the treatment to be provided extends also to providing the costs of treatment, preferably in writing. The issue of costed written treatment plans is a requirement in certain circumstances when providing treatment under NHS contract.¹⁹

VOLUNTARINESS

In the definition in bold above, consent must be given voluntarily and freely without coercion or pressure on the patient to accept or decline the treatment on offer. This in itself is very much the essence of the transaction between dentist and patient. While we may no longer accept the imperiousness of paternalism, in reality the everyday relationship of treatment decisions is based on the inherent trust the patient has in their clinician. This is not an equal relationship and a clinician can influence a patient in any way they want by dint of information, body language, pitch, tone and emphasis. If a dentist does not want to do a particular treatment, exaggerating its complexity, overstating the side effects, magnifying the postoperative complications or embroidering the description of the procedure with judiciously graphic details may all be construed as providing adequate information to the patient but may have the desired effect of the patient being lead along a path of treatment that they might otherwise not have chosen. This is coercion not far removed from the

unethical life insurance sales pitch that we may from time to time be subjected to.

A consent obtained by misrepresentation or fraud is legally viewed as no consent at all, and from an ethical point of view there can be no moral authorisation for treatment since it violates the patient's dignity and right to self determination. This coercion may be subtle, ranging from issues of quality, price and value, and may be influenced by the practice environment, the dentist's personality or other team members. Of course the coercion may be exercised with benevolent intentions where the practitioner and patient differ in their assessments of how the patient's welfare is best served,²⁰ and in this case it would be difficult to argue that consent had been vitiated.

It is very much the case that even when patients do understand information about available treatment options, they do not necessarily wish to make such choices themselves, preferring to leave final decisions in the hands of their clinicians.²¹ Many will specifically ask for your recommendations in the context of 'If it was your tooth, what would you do?' This might at face value seem to be at odds with the discredited concept of paternalism in healthcare.

The other important aspect of voluntariness of consent is that it is provided on a continuing basis. In simple terms this can mean that a patient may withdraw their consent to a procedure at any time, even if they are in the middle of it. They may do this because they have changed their mind but more probably because they are in extreme pain. This may be to 'temporarily withdraw consent'²² simply to relieve the pain but it could also be a permanent withdrawal of consent with the patient declining any further interventions. It is a feature of dental treatment that the patient will be unable to verbally communicate their decision to stop treatment since the dentist will have fingers or instruments in their mouth, and so it must be assumed that the dental team are always alert to the patient experiencing pain, or wanting to stop treatment. An agreed signal may obviate such problems.

Conditions do change through the course of treatment and new circumstances may require a change of plan. It is important that the patient is made aware of any new

situations and the attendant costs. For example, while a patient may have consented to root canal treatment having been provided with adequate information prior to commencing treatment, if it becomes apparent that the treatment is now complicated by undiscovered or sclerosed canals, the patient should be informed and invited to consider the matter further. This may precipitate a discussion about a specialist referral or different treatment options including, for example, an extraction. This may then lead to further discussion about the alternatives following an extraction and it is important the patient is apprised of these options and their costs as well. This may well take some time to explain and it may be necessary to book further appointments to discuss this if the patient is in any doubts about their options.

WRITTEN CONSENT

Having considered all of the above it would seem anachronistic to contemplate committing all the issues of capacity, knowledge, voluntariness and continuous consent to a written document. It is for that very reason that a written consent form cannot be considered a substitute for obtaining valid consent, nor an end in itself.

The act of signing a consent form does not of itself ensure knowledge is acquired or retained, with one particular study demonstrating that two to five days after an in-patient operation, 27 out of 100 patients did not know which organ had been operated on and 44 did not know the details of the operation, for example that a gall bladder had been removed.²³

Patients tend to view consent as a ritualistic and a bureaucratic hurdle, often

believing the primary purpose of the form was to protect the hospital²⁴ when done in a secondary care setting. The Department of Health has produced a guide to consent²⁵ and a generic written consent form which has been widely used in hospitals. It is somewhat unwieldy for use in general dental practice but Dental Protection Ltd in association with Admor²⁶ have produced more focused consent forms for procedures that commonly give rise to confusion or complaint, including a refusal of periodontal treatment form. The purpose of these forms is to assist the practitioner in the process of obtaining consent and while a patient may still argue they did not really understand what they had or had not consented to, the mere existence of the form will go some way to explaining how the clinician attempted to obtain consent.

While obtaining valid consent is an absolute prerequisite for dental treatment, what is equally important is ensuring that the consent process is recorded in the clinical notes in some shape or form. This may be in the form of the written consent described above or other supporting documents, or it may take the form of a shorthand description of the discussion that took place.

In the articles to follow, treatment planning is considered the most important aspect of delivering any dental care to patients. In order to construct these plans the patient's wishes and views must be taken into consideration so that valid consent is provided. This conversation is the dialogue of success.

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