

## Consent for care in dentistry

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### Introduction

Consent can be defined as the voluntary and continuing permission of the patient to receive a particular treatment. It must be based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment, including the likelihood of its success and any alternative to it" (1).

A patient's informed consent to investigations or treatment is a fundamental aspect of proper provision of dental care. Without informed consent to treatment, a dentist is vulnerable to criticism on a number of counts, not least those of assault and/or negligence - which in turn could lead respectively to criminal charges and/or civil claims against the dentist. The question of consent arises increasingly in day to day practices and matters on professional ethics and conduct are of paramount importance. Therefore, every practicing dentist, therapist and hygienist needs not only have thorough understanding of the principles of consent, but also an awareness of how to apply these principles in the wide variety of circumstances that can arise in the practice of dentistry (2).

The law is continually changing and developing, as the courts interpret both the common law and legislation. The doctrine of precedent means that judgments from a higher court will bind a lower court. At the same time, clinical knowledge and ability have developed, and this makes the interpretation of what constitutes informed consent and who can give it, a constantly changing perspective. Clinicians have a responsibility to ensure that every effort is made to meet the changing standards and to show not only that the optimum treatment is being given to their patients, but also that the patients themselves have had the best opportunity to be involved in decision making about the care of their bodies (3).

When considering consent, it is important to ask a number of questions; (4,5)

1. What does the patient or the patient's care taker need to know and understand?
2. Is the patient capable of understanding?

3. Does the patient have capacity to give consent?
4. If not, is the care taker not only capable, but also qualified to consider the best interests of the patient?
5. Is consent given voluntarily?
6. Does the law of the land give any guidance on the value of the opinion of dentists, patient or care taker?
7. Does the law resolve any conflict between patient and care taker?

The subject of consent, then, can be rather more involving than it might first appear – although dental practice is spared of the most complex and sensitive dilemmas that are faced in medical practice.

### Consent for treatment

Essentially, an informed decision about treatment has four elements namely autonomy, competence, authority and absence of coercion.

#### 1. Autonomy

There are two main characteristics of autonomy which are choice and free will (2,6,7).

A centrally important feature of patient autonomy is the right of a patient to make a clear choice. That choice needs to be made according to the patient's own values and priorities although a reasonable choice to one person may not be reasonable to another (including the treating practitioner) because the clinician may not hold the same personal values as the patient who is making the choice.

Sometimes conflict in perspectives arises in dental practice when patients ask dentists or other dental professionals to proceed with treatment which is at odds with the dentist's own values, ethics and professional judgment. Here both parties have the right to hold their view, and sometimes the solution is for the clinician to withdraw from treating the patient.

A second feature of autonomy is the need to ensure that any decisions are taken freely, voluntarily and without coercion. This is easier to say than to achieve. Coercion can be overt or more commonly it may be subtle. From an early age humans learn to adapt to situations and to make the best of situations to their own advantage. Our codes of conduct and values influence the way we behave and react to situations. Even with the best intentions we often try to influence how others might act around us.

An example in dentistry might be a teenage child who presents with his/her parents for orthodontic treatment. The parents clearly want the child to have orthodontic treatment for cosmetic reasons and the orthodontic treatment may even be judged to be in the child's best interests by both parents and the treating practitioner(s). The child may have a malocclusion that is severe and would greatly benefit from the proposed treatment. But notwithstanding the best of intentions on the part of the parents, the child may still feel coerced into having treatment which goes against his/her own wishes as regards his/her own body. In many countries parents may even have a legal right to make a decision on behalf of a child, notwithstanding a child's personal preferences (8,9).

If one examines consent purely from the point of view of autonomy then any consent obtained in that situation may not be valid if the child has not made the decision with his / her own free will. Even if the child agrees, a clinician may find it difficult to ensure that there is no undue influence being placed upon the child in reaching that decision (10,11).

We can influence patients consciously or subconsciously by the way we communicate with them. For example; some patients will be particularly reactive or sensitive to the use of certain words like "cut", "drill", "inject", "bleeding", "painful" etc. When discussing a procedure face to face a dentist can easily see this reaction, and deal with it there and then. But when a dentist communicates in writing using the same words such an opportunity is lost (12).

The pace at which we speak, how loudly or softly, and how clearly we articulate our words, the pitch and timbre of our voice, can all influence how others react to what we say. If we want to stress or emphasize something important, we should speak more slowly and clearly, and perhaps a little louder. This helps to differentiate this information from less

critical discussions, during which we might speak a little quicker and with less emphasis. In general, a higher pitch conveys nervousness or uncertainty, while a lower pitch – particularly when accompanied by speaking more slowly – tends to communicate calm, confident, authority and a feeling that everything is under control (9,10,12).

Non-verbal communication such as eye contact, facial expression, posture and gestures, will all form part of the message that a patient receives when we are communicating with them. Sometimes deliberately, sometimes unconsciously, we send the patient non-verbal signals that either accentuate, or detract from the actual words we might have used. Good eye contact communicates honesty and sincerity whereas avoidance of eye contact suggests the reverse.

In other countries, dentists use leaflets, brochures and pictures, videos and commercial CD/DVD programmes, to complement any verbal explanations of procedures. These, too, can often lead a patient to form a particular opinion. Some (especially those sold with the intention of promoting the uptake of a particular form of treatment, rather than providing general information and patient education) are intended to make one form of treatment sound a lot more attractive than alternative options. These visual aids can become pivotal evidence if and when a dispute arises over what a patient was and was not told, and the extent to which they might have been misled or denied important information. Therefore, it is important to reassess all the information material to be used to reflect how fair, balanced and accurate it is. The risk of a one-sided picture being created in the patient's mind is greater when using material that has been created by manufacturers and suppliers. Not all such leaflets fall into this trap – but unfortunately for the dentists concerned, many do, making it much easier for the patient to suggest that they were "talked into" or "sold" some dentistry without having been made fully aware of its possible risks and limitations (13).

It is not the dentist's right to carry out treatment without fully involving the patient in the decision-making process because it is unfair and immoral to deprive patients their right of autonomy and self-determination. Giving patients opportunity to choose treatment option is one way of showing respect to them, but a patient cannot exercise the power to choose unless they have sufficient, meaningful and

balanced information to support that process (11,12,14).

Therefore a dentist should be prepared to spend time and effort to share knowledge of the procedure(s) in question, and their likely outcome, so that the patient is better placed to understand the options available to them.

Making this investment of time and effort helps to build trust, confidence and a strong relationship between a dentist and the patient, as well as laying the foundations for an effective, valid consent process.

In Tanzania like many other countries the moral principle of consent is reflected as a respect for personal autonomy as soon as a person is able to make decisions for him/herself. However, patients rarely exercise their right of autonomy because they totally submit themselves to doctors and rely on them to make decisions on treatment issues (8,9).

## 2. Competence

Competence in this context means the patient's ability to understand the explanations given, about the nature and purpose of a particular procedure, its likely effects or risks, any alternative treatment and how these alternatives might compare. In order to understand the information provided, and to give the necessary authority for consent, a patient must be competent. Only when a patient is competent to consent, can the patient's consent be considered valid.

The patient may lack competence for a number of reasons for example he/she might be unconscious or suffering from temporary or permanent form(s) of mental impairment. On the other hand, a young child will clearly not have the competence to consent to a dental procedure. Dentists should not assume that a child who is at school age or is 16 years old is therefore competent to consent. Most children eventually reach an age where they can grasp relevant facts about their body and about proposed treatment. In order to protect children, laws exist in many countries defining the age at which children can normally be considered capable of making their own decisions in this respect. Many countries Tanzania inclusive permit an individual of 16 years old or over, and of sound mind to give a legally valid consent to dental treatment; however, it does not preclude children under 16 years old from giving consent (8-10).

## 3. Authority

Authority is the power or right to give orders, make decisions, and enforce obedience: or the right to act in a specified way, delegated from one person to another. Clearly, in the case of a patient aged 16 years or over who is with healthy mind, he/she has the authority to give or withhold consent to any treatment proposed for himself/herself, and it could be held to be an act of assault to violate the patient's autonomy and right of self-determination by providing treatment against his/ her declared wishes (11).

Most children eventually reach an age where they can grasp relevant facts about their body and about proposed treatment to it. They can give consent to treatment, but the degree of understanding can vary in relation to the complexity of the treatment envisaged. A few children are never, even when adulthood is reached, capable of properly understanding the information given to them and must therefore be considered incapable of giving consent (9).

A person must be assumed to have authority unless it is established that he /she lacks capacity. Such a person should not be treated as being unable to make a decision unless all practicable steps to help him/her to do so have been taken without success. Any act done or decision made for or on behalf of a person who lacks capacity to authorize must be done or made in his/her best interests. Before the act is done, or the decision made, regard must be considered to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action (2,11,12).

## 4 Absence of coercion.

Coercion is the act of compelling by force of authority. Thus lack of coercion in dental practice is a circumstance that allows a patient to voluntarily consent for treatment.

It is important that no misleading information is offered and ample time is provided to a patient to facilitate voluntary consent. It is also important to note that the patient has mandate to refuse or opt out at any stage of treatment, even though such treatment may be aimed to be in the best interests of the patient and failure to have it may be harmful (3,9,10).

**Possible consequences of not obtaining consent for treatment**

Two areas of the law are relevant namely trespass and negligence.

1. If invasive treatment is provided without patient consent to the general nature of the procedure, then a practitioner may be sued for the tort of battery, and damages claimed for trespass to person unless the failure to obtain consent is justified by necessity: such as an emergency. However, the role of the law of trespass in the area of 'informed consent' is limited because consent to a procedure is not usually negated by being obtained without disclosure of associated risks and possible alternative treatments.
2. The most applicable sanction for failure to disclose this sort of information lies in the tort of negligence. It is accepted that a practitioner's general duty to act reasonably includes a duty to provide adequate information, particularly in relation to risks or hazards. If something goes wrong then the practitioner may be exposed to liability for damages in negligence.

A negligent act is usually found or alleged to have occurred in the procedure itself. However, a failure to provide information about the procedure and associated risks may also amount to negligence.

For action in negligence related to failure to provide information to succeed, two points must be established:

- (a) That failure to disclose the information was unreasonable
- (b) The measure of reasonableness in relation to information-giving is akin to the standard of care required in relation to diagnosis and treatment, viz. that of an 'ordinary careful and competent practitioner of the class to which the practitioner belongs'. To satisfy the second element (causation), the patient must establish both that he/she would not have consented to the treatment had proper disclosure been made and that injury was suffered due to the treatment (11,12).

**How to practice**

Most procedures carried out in general dental practice would be considered minor. However, an extensive treatment plan composed of numerous minor items will require elaboration, as will be the more costly or controversial items. The magnitude and/or likelihood

of possible harm should clearly be evaluated and explained.

Information about the possibility of serious harm must be given even if the chance of it occurring is slight. Similarly, information must be given if the potential harm is relatively slight but the risk of it occurring is great.

Typical risks in general dentistry which may need to be mentioned include nerve damage in oral surgical procedures, perforation or possibility of instrument breakage in endodontic treatment, and crown and bridge failures. It is probably not necessary to discuss risks that are inherent in any operation, such as post-operative infection (2,3,11).

The personality, temperament and attitude of the patient;

More information must be given to those keen to have it for more than just reassurance, especially in response to specific questions. On the other hand, it is not necessary to force information on a patient who is prepared to leave all decisions to the service provider.

On occasions, and most rarely in dentistry, it would be considered justifiable not to volunteer certain information if there are reasonable grounds for believing that the patient's health or welfare might be seriously harmed by being given the information.

**The patient's level of understanding**

Without it being necessary to cross-examine a patient to ascertain understanding, information-giving should be influenced by some appraisal of the patient's intelligence and apparent understanding to enable a clinician provide information that will be understood by the patient. Seeking some feedback from the patient may give an indication of his/her comprehension (12,13).

**Permanent records**

In all situations it is necessary to keep clear records. Disclosure of information and subsequent oral consent (which suffices for the vast majority of dental procedures) should be listed in the clinical notes.

For major treatment, either in terms of invasiveness or expenses, written consent forms acknowledging that the nature, implications and risks of the proposed procedure have been explained must be signed.

Whenever in doubt about whether a procedure is major or minor, written consent should be obtained. An appropriate alternative may be to have adequately written records of the information given, shown to and initiated by the patient.

#### **Potential controversies**

Dentists must take care always to mention any proposed use of treatments which, although considered standard, safe and minor procedures by the dental profession, might be regarded with some doubt by certain patients (for example, X-rays or amalgam fillings), so that these patients have the opportunity to request further information or decline such treatment modalities.

Procedures which have yet to receive general acceptance as standard or desirable practices, or which do not accord with mainstream dental opinion, necessitate the precaution in every case of ensuring that "fully informed" consent is forthcoming (13,14).

#### **Less tangible items of treatment**

Genuine service should be free from any suspicion of over servicing.

Consent for relatively minor procedures which might not be very apparent after completion, such as occlusal adjustment, recontouring of existing restorations or fissure sealants, especially if numerous, will often require fuller justification than more obvious items.

#### **For Situations in which authority is not clear**

If a practitioner cannot be certain that consent is valid: for example, where there is conflict between the parent and a child, or where a child or another legally incompetent person is under the control of a person not normally authorized to give consent; then it would be unwise to proceed with treatment (except in the case of an emergency) until the situation is clarified (9,14).

#### **Treatment alternatives**

Where alternative treatments have been expounded, a dentist should accept the patient's preferred option within reason. For instance, few dentists would have problems about providing a partial treatment of the patient's choice which, although included among discussed options, has been recommended against or declared undesirable: for example, the provision of an immediate full denture rather than a recommended course of relatively simple conservative work. In the

event of problems, it is preferable not to have acted contrary to one's own recommendation.

If any part of an accepted treatment plan is to be delivered by someone other than the dentist presenting it, such as another dentist or oral health personnel within the practice, then the patient must be made aware of this in advance (15).

#### **Summary**

It is recommended that dentists should;

1. Respect any patient's fundamental right to decide whether or not they wish to proceed with any dental treatment.
2. Assess the patient's competence to consent, bearing in mind their age and their ability to understand;
  - a) the nature of the proposed treatment
  - b) its purpose
  - c) any risks and limitations
  - d) comparisons with any alternative treatment options which are available (including that of doing no treatment at all)
3. Satisfy oneself regarding the authority of the patient (or that of anyone else acting on the patient's behalf) to give consent to the proposed treatment.
4. Provide the patient with as much information as is appropriate and relevant (and as is required by the patient). Invite questions from the patient, and answer any such questions fully, truthfully and fairly, trying to avoid making any dismissive comments about any possible risks.
5. Satisfy oneself that consent has been given voluntarily.
6. Bear in mind the situations where it might be sensible to give written information/ warnings as part of the process of obtaining a valid consent from the patient, and where written consent is a requirement in the country.
7. Keep good and careful records of all matters concerning consent

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