

CONSENT

AUSTRALIA



CONSENT TO DENTAL TREATMENT

THE PRINCIPLES AND THEIR APPLICATION

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1.0 INTRODUCTION

A patient's informed consent to investigations or treatment is a fundamental aspect of the 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. Furthermore, the question of consent arises increasingly at the heart of complaints made to the Australian Health Practitioners regulation Agency (AHPRA) which underpins the decisions of the Dental Board of Australia when it considers matters of professional ethics and conduct.

It is self-evident, therefore, that every practising dentist, therapist, hygienist, OHT and prosthetist needs not only a 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 practise of dentistry.

The law is continually changing and developing, as the courts interpret both the common law and legislation. The doctrine of precedent means that judgements 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 keep abreast of changing standards, 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.

Nearly eighty years ago, Judge Cardozo in a case in America declared:

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body."¹

The concept of patients' rights, adult responsibility and a mind sound enough to understand, are embodied in the principles of consent. In 2010 AHPRA defined consent in the Code of Conduct regulatory standard as:

*'A persons voluntary decision about health care that is made with knowledge and understanding of the benefits and risks involved.'*²

This has been further defined in 2012 in The Australian Dental Associations Policy Statement 5.15 'Consent to Treatment' as the:

*The voluntary agreement by a competent patient to a proposed procedure or treatment.*³

When considering consent, it is important to ask a number of questions.

- What does the patient or the patient's carer need to know and understand?
- Is the patient capable of understanding?
- Does the patient have capacity to give consent?
- If not, is the carer not only capable, but also qualified to consider the best interests of the patient?
- Is consent given voluntarily?
- Does the law of the land give any guidance on the value of the opinion of dentists, patient or carer?
- Does the law resolve any conflict between patient and carer?

The Australian Federal Parliament has enacted a number of laws intended to protect human rights and prevent discrimination. Perhaps key in understanding consent however is the Australian Human Rights Commission Act 1986 which contains the following articles which may be relevant in medical law cases:

- Article 1 (the right of self determination)
- Article 6 (protection of the right to life)
- Article 7 (prohibition of torture, inhuman or degrading treatment)
- Article 9 (right to liberty and security)
- Article 17 (right to respect for private and family life)
- Article 18 (freedom of thought, conscience and religion).

The subject of consent, then, can be rather more involved than it might first appear - although mercifully we in dentistry are spared many of the most complex and sensitive dilemmas that are faced by some of our medical colleagues.

1. Schloendorff v Society of New York Hospital 105 NE 92 [NY 1914]

2. AHPRA - Code of Conduct, date of current of current version 17 March 2014

3. ADA Policy statement 5.15, Consent to Treatment (including ADA Guidelines for Consent for Care in Dentistry) adopted by ADA Federal Council, November 15/16 2012

2.0 ASPECTS OF AUTONOMY

Depending on where one goes in the world, autonomy can mean different things. In most western countries, the moral principle of consent is reflected in a respect for personal autonomy as soon as a person is able to make decisions for him/herself. Here, the growing emphasis on patient autonomy in recent years contrasts with the historical position – sometimes described as the “Doctor knows best” era of medical paternalism.

In some countries, although certainly no longer in Australia, medical paternalism is alive and well and patients may still be happy to defer to whatever their treating clinician is recommending for them, with little or no questioning or challenge. In some cultures personal autonomy may not be regarded as being quite so important and the roles of the families or elders within families may have a far greater influence.

These national and cultural differences become all the more significant now that both patients and healthcare professionals have become more mobile, and dentists find themselves treating more and more patients from different cultures. Australia, in particular, has become highly multi-cultural at quite a rapid pace, and yet few dentists have undertaken any specific training to help them to understand and prepare themselves for the possible implications – this is another reason why consent has again become such a hot topic medico-legally.

A landmark legal case (3) involving a medical practitioner (a surgeon) broke new ground just a few years ago and demonstrated just how far the UK courts would go in order to uphold patient autonomy, even in the face of well-established legal principles:

“I start with the proposition that the law which imposed a duty to warn on a doctor has, at its heart, the right of a patient to make an informed choice as to whether, and if so when and by whom, to be operated on.”

Sir Denis Henry – Appeal Court Decision (UK) Chester v Afshar⁴, Paragraph 86.

This decision was later supported by a majority decision in the House of Lords, even though (as stated in Lord Bingham’s dissenting opinion)

“The injury would have been just as likely to occur whenever the surgery was carried out, and whoever performed it.”

Lord Hope, on the other hand, was clearly more anxious to find a basis upon which to support the plaintiff (patient) in her claim and find the surgeon (Mr Afshar) guilty of negligence on the consent issue. But the law relating to negligence requires there to be a direct causative link (“causation”) between the surgeon’s omission in having failed to warn the patient adequately, and the harm that resulted. In this case, there was no disagreement that the surgery itself had been provided to a perfectly appropriate standard – the case was pleaded on the basis that “but for” the lack of adequate warnings, the patient would not have gone ahead with the surgery that resulted in the adverse outcome.

In the House of Lords decision, Lord Hope explained:

“It is plain that the “but for” test is not in itself a sufficient test of causation. A solution to this problem which is in Miss Chester’s favour cannot be based on conventional causation principles. The issue of causation cannot be separated from issues about public policy. The law has as its heart the right of the patient to make an informed choice as to whether and if so, when and from whom to be operated on. For many the choice would be a difficult one, needing time to think, take advice and weigh up the alternatives.”

Lord Steyn, also supporting the patient’s claim, expressed this view:

“As a result of the surgeon’s negligent failure to warn the patient, she cannot be said to have given her consent to the surgery in the full legal sense. Her right of autonomy and dignity can and ought to be vindicated by a narrow and modest departure from traditional causation principles.”

This ground-breaking case happened to arise in the UK, and happened to involve a medical practitioner. But in country after country around the world, the courts are stepping in to swing the pendulum very much in favour of the patient when matters of consent are under discussion. In the above case, the Court of Appeal and the House of Lords both concluded that the normal application of the law would result in the clinician being found not guilty of negligence – so they departed from traditional principles in order to find him guilty!

There are several aspects of autonomy which need to be considered, including:

4. Chester v Afshar [2004] UKHL 41

Choice

A centrally important feature of patient autonomy is the right of a patient to make a clear choice – as illustrated in the Chester v Afshar decision above. That choice needs to be made according to the patient’s own values and priorities.

A reasonable choice to one person may not be reasonable to another (including the treating practitioner) because this clinician may not hold the same personal values as the patient who is making the choice.

This conflict in perspectives sometimes 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 judgement. Here both parties have the right to hold their view, and sometimes the solution is for the clinician to withdraw from treating the patient.

Free will

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 that 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 their 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.

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. We will discuss this further at 3.01 overleaf (page 7).

2.1 INFLUENCE

We can influence patients consciously or subconsciously by the way in which we communicate with them. For example:

The words we use

Whether the words are written or spoken, a patient’s perception can easily be influenced by the words that we choose to use. Some patients will be particularly reactive or sensitive to the use of certain words (eg, “cut”, “drill”, “inject”, “bleeding”, “painful” etc); when you are discussing a procedure face to face you can usually see this reaction, and deal with it there and then. But when you use the same words in a letter, you don’t get this opportunity.

Our voice

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 might react to what we say. If we want to stress or emphasise 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.

Non verbal communication (“body language”)

Our eyes, our face, our posture, our 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.

Images

Many 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. All the more reason, therefore, to reassess all the information material that you use, and to reflect upon 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.

2.2 RESPECT

This brings together the ethical and human dimensions of consent (see opening section 1.00), and can be summarised as dealing with patients as we would wish to be dealt with ourselves, or as we would hope and expect that another health professional might deal with us or a member of our family.

It is not our right to carry out treatment on another person, without fully involving them in the decision-making process. It is not fair, moral or decent to deprive another person of their right of autonomy and self-determination. For a healthcare professional to act in such a way in relation to someone under their care is particularly unacceptable, given the special relationship of trust that exists (or should exist) between a patient and that healthcare professional.

Giving patients choices is one way of showing our respect for them, but a patient cannot exercise that choice unless they have sufficient, meaningful and balanced information to support that process.

In any relationship between a lay person and a professional person there tends to be a wide gulf between the relative levels of knowledge and understanding. It is the professional person's responsibility to close that gap by being prepared to spend time and effort in sharing their special 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 a stronger relationship of trust and confidence between you and the patient, as well as laying the foundations for an effective, valid consent process.

3.0 COMPETENCE

In order both to understand the information provided, and to give the necessary authority for consent, a patient must be competent. **“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 and risks; and
- Any alternative treatment and how these alternatives might compare.

Only if a patient is competent to consent, can the patient’s consent be considered valid. The patient may lack competence for a number of reasons; they might be unconscious or suffering some temporary or permanent form of mental impairment. On the other hand, a very young child will clearly not have the competence to consent to a dental procedure.

Many practitioners assume that competence is achieved once a minor reaches the age of majority, which is deemed 18 under the Australian law however this may not necessarily be the case. Most children eventually reach an age where they can grasp relevant facts about their body and about proposed treatment to their body. A few children are never, even when adulthood is reached, capable of properly understanding the information given to them and then must therefore be considered incapable of giving consent.

The legislation defining the age at which children can normally be considered capable of making their own decisions is complex and varied in Australia⁵; with each State and Territory having a government office or statutory authority responsible for coordinating the policies affecting children and youths⁶. Consequently, the age of consent to medical treatment varies across jurisdictions, ranging from eighteen years of age in Western Australia⁷ to fourteen in NSW.⁸ Generally however, treatment provided to children under the age of sixteen also requires the consent of their parent or guardian.

Many members will be familiar with the Gillick⁹ case in the UK, which related to the provision of contraceptive aids to girls less

than 16 years of age, without parental consent. This decision has been upheld in Australia¹⁰ and this has been crystallised in South Australia where the Gillick test has been modified by statute to be;

*If the child consents, and (1) the medical practitioner is satisfied that the child is capable of understanding the nature, consequences and risks of the treatment, and that the treatment is in the best interests of the child’s health and wellbeing; (2) and that this opinion of the medical practitioner is supported by the written opinion of another medical practitioner who has also examined the child.*¹¹

As a result of these cases, the view is generally held that children, if they can fully understand the proposed treatment, can give consent to that treatment. Dentists should always try to confirm that both the child and the parent understand the treatment to be given. Even in cases where it is believed that the child may be capable of giving consent which (according to Gillick) would negate the need to obtain parental consent, it is still wise to try to seek the child’s permission for a discussion with the parent to confirm their agreement.

If a parent is not available when children under 16 years of age are examined, then extreme caution is advised. A few years ago, the Court of Appeal in the case Re-R12 decided that where a child under 16 refuses consent to treatment, that consent could be obtained from a parent.

“The failure or refusal of the “Gillick Competent” child is a very important factor in a doctor’s decision whether or not to treat, but does not prevent the necessary consent being obtained from another competent source.”

This decision could only lead to further confusion and difficulty. As a result, consideration should be given to refusing treatment (except in an emergency) if concern remains about the quality of the understanding and agreement of both child and parent.

In broad terms, and on consideration of the case law and underpinning legislation, Dental Protection would thus advise that it is appropriate to try to encourage the patient and consenting adult to reach a consensus.

5. For example, see Minors (Property and Contracts) Act 1970 (NSW) § 9; Age of Majority Act 1974 (Qld) § 5(2).

6. Three states have established independent bodies to review and advise on issues relevant to children. These are: New South Wales (Commission for Children and Young People); Queensland (Commission for Children and Young People and Children’s Guardian); and Tasmania (Commissioner for Children)

7. Age of Majority Act 1972 (WA) § 5. Also see: Western Australian Government, Consent to Treatment Policy for the Western Australian Health System, Department of Health 2006

8. Minors (Property and Contracts) Act 1970 (NSW) § 49

9. Gillick v West Norfolk v Wisbeach Area Health Authority [1986] AC 112

10. re Marion (1991) FLC 92-193. Secretary of the Department of Health and Community Services v JWB and SMB,

11. Consent to Medical Treatment and Palliative Care Act 1995 (SA) § 12.

12. Re-R(A Minor) 1991 4 ALL ER

4.0 AUTHORITY

4.1 COMPETENT ADULTS

Clearly, in the case of an adult aged 16 years or over who is of sound 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.

4.2 CHILDREN

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.

In Australia the Family Law Act 1975 defines who has parental responsibility and the consequent right to give consent to a child's treatment. In situations where there has been a dispute, this can be set down in a court ordered parenting plan.

Other people may gain parental responsibility by court order or by being appointed guardian upon the death of the parents. If the child is the subject of a care order, the court can amend the parenting plan to contain child welfare provisions.

If two people have parental responsibility for a child, one can be given access without the other being informed. For example, if a child lives with its mother, the father can obtain access without the mother being informed. There are a limited number of procedures where both individuals holding parental responsibility must give consent including vaccination and circumcision.

Difficulties can arise with determining parental consent, and in these cases caution is advised and consideration should be given to the merit of withholding treatment if doubt exists.

4.3 THE INCOMPETENT ADULT

There is a plethora of legislation surrounding the provision of medical treatment to an incompetent adult, and naturally this varies on a State and territory basis. At this stage there is no overarching National Mental Health Act. However, mental health legislation is currently under review¹³ and this document will be updated in accordance with the new legislation in due course.

In the interim, it may be helpful for the practitioner treating adults who may lack capacity, to reflect on the following¹⁴:

1. There is a **presumption of capacity**. Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
2. People should receive **support to help them make their own decisions**;
3. **Unwise decisions** – people have the right to make decisions that others might think unwise;
4. **Best interests** – an act done for, or a decision made on behalf of, someone who lacks capacity must be in their best interests;
5. **Least restrictive option** – anything done for or on behalf of a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

13. The Mental Health Bill 2014, An explanatory guide

14. Summarised from the Mental Capacity Act Code of Practice 2005. Code of Practice. Department of Constitutional Affairs 2007

4.4 ASSESSING LACK OF CAPACITY

An individual's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.

This means that a person may lack capacity to make a decision about one issue but not about others. Care must be taken not to judge an individual's capacity merely by reference to their age, appearance or medical condition.

Supporting the person to make the decision for themselves

It is important to take all possible steps to try to help people make a decision for themselves before deciding that someone lacks capacity to make a particular decision. At the lowest level, the person should at least be involved in the making of that decision, wherever possible. In order to enable this, it is important to provide all necessary relevant information.

Two-stage test of capacity

Naturally, impairment can be both intermittent and constant, consequently it can be helpful to consider capacity using a two-stage test.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does that impairment mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing the ability to make the decision

A person is unable to make a decision for himself if s/he is unable:

- To understand the information relevant to the decision;
- To retain that information;
- To use or weigh that information as part of the process of making the decision; or
- To communicate his decision (whether by talking, using sign language or any other means).

The person must be able to hold the information in their mind long enough to use it to make an effective decision. However, people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide.

4.5 BEST INTERESTS

If a person has been assessed as lacking, or is reasonably believed to lack, capacity to make the decision in question or to give consent it is then necessary to weigh up what is in the person's best interests. An act done or a decision made for or on behalf of a person who lacks capacity must be in that person's best interests.

A person trying to work out the best interests of a person who lacks capacity to make a particular decision should:

Encourage participation

Do whatever is possible to permit and encourage the person to take part, or to improve their ability to take part, in making the decision.

Identify all relevant circumstances

- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves.
- Try to find out the views of the person who lacks capacity, including:
 - The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits.
 - Any beliefs and values (e.g. religious, cultural, moral or political) that would be likely to influence the decision in question.
 - Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves.

Avoid discrimination

Not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour. Assess whether the person might regain capacity

Assess whether the person might regain capacity

- Consider if the person is likely to regain capacity (eg, after receiving medical treatment). If so, can the decision wait until then?

Consult others

- If it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:
 - Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues.
 - Anyone engaged in caring for the person.
 - Close relatives, friends or others who take an interest in the person's welfare.
 - Any attorney appointed as an Enduring Power of Attorney made by the person while they still had capacity. This appointed person must be over 18 years of age.
 - Any deputy appointed by the Court of Protection¹⁵ to make decisions for the person.
- For decisions about major medical treatment, where no-one fits into any of the above categories an independent Tribunal may be formed to make these decisions, or appoint an appropriate person or persons to do so.

Avoid restricting the person's rights

- See if there are other options that may be less restrictive of the person's rights.
- Weigh up all of these factors to work out what is in the person's best interests.

4.6 RECORD KEEPING

A detailed record should be kept of the decision process for assessing the best interests of that person for each relevant decision. These should be in keeping with the Dental Board of Australia Guidelines on Dental records¹⁶. The record should set out:

- How the decision about the patient's best interests was reached;
- What the reasons for reaching the decision were;
- Who was consulted to help work out best interests; and
- What particular factors were taken into account?

15. Via the Office of the Adult Guardian

16. www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

17. Powers of Attorney Act 1998, s63

18. See 20

4.7 SITUATIONS IN WHICH A DESIGNATED DECISION – MAKER CAN ACT ON BEHALF OF SOMEONE WHO LACKS CAPACITY

Enduring powers of attorney (EPA)

A patient's relative may explain that they have a power of attorney. An enduring power of attorney (EPA) enables a named person to make decisions on their behalf in respect of property and financial affairs as well as their personal health matters, which includes providing consent to or declining treatment of behalf of the 'protected adult'. Alternatively, a statutory health attorney can be appointed under the Guardianship and Administrative Tribunal Act 2000. This person must be readily available and culturally appropriate¹⁷. If no person is readily available then the public guardian is the adult's statutory health attorney for the matter.¹⁸

Court appointed deputies

The Act provides for a system of court appointed deputies. Deputies will be appointed to take decisions on healthcare but will only be appointed when the Court cannot make a one-off decision to resolve the issue.

Each case needs to be assessed carefully on its merits. If in doubt, defer treatment and seek advice either from colleagues, or from one of the dentolegal advisers at Dental Protection.

4.8 INFORMATION GIVEN TO A PATIENT

There are differing views held throughout the English speaking world on what constitutes the answer to the question "What does the patient need to know?" In England and Wales, the best known interpretation of English law on the subject is to be found in the case of *Sidaway*¹⁹. In this case, five Law Lords had to decide whether or not Mrs Sidaway had the prognosis and the sequelae of a difficult operation on her back properly explained to her prior to the operation. She had suffered permanent nerve damage as a result of the operation.

The attitude of the law to a doctor or dentist's duty is measured in courts in England and Wales by the application of what is known as "The Bolam Test".

This is a standard that arose from a speech given by McNair J in *Bolam v Friern Barnet Hospital Management Committee*²⁰, which was a major landmark in defining the duty of care that a doctor owed to a patient. McNair J stated,

"The test (whether there has been negligence) is the standard of the ordinary skilled man exercising and professing to have that special skill."

The best summary of this case came from Lord Diplock who felt that the “Bolam Test” was,

“Applicable to every aspect of the duty of care owed by the doctor to his patient, in the exercise of his healing functions, as respects that patient.”

The case of Sidaway showed that the degree of probability of a risk arising, and the seriousness of possible injury are two important facts that a patient needs to know before being able to consent to treatment. Not only does a dentist have a duty to explain relevant facts to the patient, but the language used should assist the patient to understand, and any additional points raised by the patient should also be properly addressed.

How much advice should be given and how consent should be recorded will depend upon the merits of the individual case. When a patient sits in the dental chair, it can be assumed that implied consent to a non-invasive examination only has been given. Any invasive technique that might include periodontal probing, radiographs, blood tests and diagnostic cavities would require further consent from the patient and it is dangerous to rely upon the assumption of “implied consent” to these further procedures.

Consent would normally be obtained verbally after explaining the need for the investigation and any possible sequelae.

Once the investigations are complete, the patient is entitled to advice on diagnosis and treatment planning. Where a number of alternative treatment plans are available, the choice should be explained, together with the merits and disadvantages of each plan. If a preference for one particular plan is offered, it is helpful to the patient in making a choice, if the reason for the preference is given.

Patients cannot properly consider treatment options if they are not given information on sequelae and prognosis, if either of these is pertinent. For example, where the extraction of a third molar tooth is to be undertaken a possible sequel (eg, a risk of one in ten of transient lingual paraesthesia) occurring, would certainly merit a warning to the patient²³. Patients have a right to know if their lifestyles may be compromised by a side effect of treatment. When the incidence of a possible complication is very slight, it is often considered to be in the best interests of the patient not to warn and thus risk frightening the patient, but the significance of the above possibility is very real to a professional singer, for example and a failure to elicit any relevant information about a patient and to warn them accordingly could be legally disastrous.

The concept in England and Wales has therefore been that of the prudent dentist. What would a prudent dentist explain to a patient? The answer to be found in *Bolam* is “the information which a dentist in that situation would normally be expected to explain to a patient who needs that information”.

However, there is no doubt that the situation is changing, and that the Bolam test is now considered in some quarters a rather too paternalistic, from a “doctor (dentist) knows best” perspective.

4.9 MATERIAL RISKS

In an Australian case (*Rogers v Whitaker*)²², the High Court of Australia ruled that a 1 in 14,000 risk of blindness associated with a procedure, should have been disclosed to a patient. In this example, the patient was already almost blind in one eye and the doctor should have warned of the possible risk of blindness to the other eye no matter how slight in these circumstances, regardless of whether the patient had expressly asked the question or not.

The High Court said,

“A risk is material if in the circumstances of the particular case, a reasonable person in the patient’s position – if warned of the risk – would be likely to attach significance to it, or where the medical practitioner is (or should reasonably be) aware that the particular patient – if warned of the risk – would be likely to attach significance to it.”

Consequently, the perspective of the “prudent dentist” needs to be balanced first against that of the “prudent patient” ie, what would a normal patient of sound mind, reasonably expect to know before being in a position to make a decision as to whether or not to proceed with the treatment?

Even this, however, might not be enough if the Australian precedent were to be applied more widely. What matters more, arguably, is what this specific and individual patient would wish (or need) to know before deciding whether or not to proceed with treatment. No treatment should ever be undertaken without giving the patient the opportunity to ask questions and/or raise any concerns or fears.

Where there is a high risk of failure or post-operative complication, not only should the patient be warned but a specific entry naming the complication should be made on the record card.

Many claims involving paraesthesia and also immediate dentures are successful simply because it cannot be shown later that the patient was specifically warned of the possible postoperative complications.

While on the subject of information, cost (in some branches of dentistry at least) becomes an important facet of consent. Without the knowledge of the financial and social implications of treatment, a patient cannot give a proper commitment. Where treatment is to be protracted, involved or expensive, it is worthwhile writing to the patient with an explanation of the treatment, the time it will take, prognosis, sequelae and costs. The patient can then have the opportunity to raise any enquiries before agreeing the treatment and making an appointment.

23. Sidaway v Board of Governors of the Bethlehem Royal Hospital [1985] 1 ALL ER 643 HL

24. Bolam v Friern Barnet Hospital Management Committee [1957] 1 WLR 582

25. Blackburn C.W., Bramley P. lingual nerve damage associated with removal of third molars, Br. Dent J. (1989) 167: 103-107

26. Roger v Whitaker (1992) 109 ALR 625-631 [1993] 4 med LR 79-82 (High Court of Australia)

Language is also an important element in obtaining consent. If the patient speaks a different language from the dentist an interpreter may be indicated. Whenever the common language is not the first language of either patient or dentist, then care should be taken to ensure that the points have been properly explained and understood. All specialities tend to have their own shorthand and nomenclature, and care should be taken to avoid dental “jargon”, which can also be a barrier to effective communication.

An explanation should be simple and clear. The patient’s failure to grasp information would be the dentist’s responsibility, if it can be shown that the language of the explanation was simply not understood by the patient. Special care should be taken with deaf, partially sighted or blind patients.

Consent is often given by a patient because of the apparent advantages or benefits of a particular line of treatment. Care should be taken to ensure that the information given is balanced and accurate, and can be substantiated. Statements such as “your crown will last for life”, or “your molar root treatment will be 100% successful” or “I guarantee you will have no problem” may dramatically weaken the value of the consent contained. It can also enable a patient to bring a successful claim for breach of contract at a later stage, even when no negligence is present.

Where treatment is unusual or experimental, it is important that the patient should fully understand the situation and it is worthwhile to get the patient to sign a Statement to the effect that they recognise the controversial or relatively untried nature of the treatment and accept that the risks are greater and perhaps even unknown.

Even when all the relevant facts and explanations are given to a patient, confirmation must still be obtained that the patient can understand them. This raises the question of “competence” or the patient’s capacity or ability to understand, which will now be considered.

The ADA guidelines for consent for care in dentistry²³ provide a helpful reference for obtaining and documenting consent in Australia.

4.10 EVIDENCE BASE

Some clinicians believe that patients must be provided with every last detail of the evidence base, in order to enable them to assess the information objectively and to compare alternative treatment options. Not only is this another onerous prospect for the clinician, it also fails to recognise two important aspects of the consent process.

Firstly, it is not sufficient for the clinician to present the patient with information in terms that would be meaningful to another clinician; the evidence base is useful to inform a clinician, but this is usually very different from what the patient needs to know, and how this information needs to be presented.

Secondly, while the evidence base provides information regarding what treatment is most likely to succeed, or fail, it takes no account of the particular situation and circumstances of an individual patient. Take, for example, an oral surgeon who gives a standard warning to every patient that (for example) the incidence of inferior dental nerve damage associated with the surgical removal of lower third molars, is less than one in a thousand (10).

Patient (A) has a fully erupted lower third molar, with the preoperative radiographs showing a separation of at least 8mm between the inferior dental nerve bundle, and the roots of the tooth. Patient (B), on the other hand, has a deeply impacted third molar, where the radiographs suggest a very close or intimate relationship between the roots and the inferior dental nerve. The clinician’s standard warning is clearly irrelevant and inappropriate to both of these patients.

This illustrates the danger of giving the same information to every patient, and the importance of personalising any information provided, for each individual patient. It is in this context that the *Rogers v Whitaker* judgment (see above) is helpful to us in our understanding of the patient’s perspective, even though the judgment itself has application only in Australia.

In some situations, it is clear from the clinical records that there has been at least some discussion of a particular risk, or a range of risks, in advance of treatment. But when bringing a subsequent complaint or claim, a patient will often maintain that these risks, while mentioned in passing, had been discussed in a dismissive way, as if to suggest that the risk was so small or so remote as to be almost hypothetical or theoretical, rather than a real and immediate possibility to be considered.

Clinicians will often do their very best to be reassuring – particularly when dealing with nervous patients – but one must guard against doing this in a way which leads a patient to attach little or no significance to the warning or information in question.

Patients, however apprehensive, must be left in no doubt as to the nature and extent of any risks of care and treatment that they are contemplating.

4.11 INFORMED CONSENT

For as long as healthcare professionals are encouraged to believe that providing information to a patient is alone sufficient for the purposes of obtaining a valid consent, we will continue to do our patients a disservice. The continued use of the term ‘informed consent’, used without qualification and without fully understanding the pitfalls of this perspective of consent, is certainly not helpful.

23. www.ada.org.au/app_cmslib/media/lib/1301/m479887_v1_policy%20statement%205.15%20consent%20to%20treatment.pdf

It perpetuates an outdated and paternalistic approach to patient care and those who continue to use this term do need to appreciate that the focus should be on understanding, rather than the provision of information alone. It is for precisely this reason that Dental Protection stresses that consent forms serve only to confirm some of the details of the information provided; they tell us little or nothing about the communication process, the questions asked, the replies given and the level of understanding achieved by the time the 'consent' was eventually given. Nor do they provide any insight into whether or not any undue influence was exerted upon the patient when reaching a decision. This is why a detailed contemporaneous record will often be far preferable to a signed consent form alone.

Perhaps the most convenient and concise confirmation of the prevalent abuse of the term 'informed consent' comes from one of the most highly respected and widely acknowledged authorities in the field of Medical Law, Sir Ian Kennedy and Prof Andrew Grubb. In their definitive textbook, "Medical Law"²⁴ they write:

"The aphorism 'informed consent' has entered the language as being synonymous with valid consent. This, of course, not so and is in fact unhelpful. It gives only a partial view. The requirement that consent be informed is only one, albeit a very important ingredient of valid consent. Furthermore, the expression 'informed consent' begs all the necessary questions (which are the subject of the following section); for example, how informed is informed?"

Judges in certain other jurisdictions have found more helpful ways to encapsulate the essential principles of consent. Amongst the best of these is the term "enlightened consent", which captures very nicely the idea that a patient needs to be put into a position from which they can understand the key issues which will influence their willingness (or otherwise) to undergo a particular procedure.

A patient sometimes consents to a particular line of treatment because of the apparent advantages or benefits as described by the dentist. Care should be taken to ensure that the information given is balanced and accurate, and that any claims (as to likely success) can be substantiated. Statements such as "your crown will last for life", or "your molar root treatment will be 100% successful" or "I guarantee you will have no problem" may dramatically weaken the value and validity of the consent contained.

Where treatment is unusual or experimental, it is important that the patient should fully understand the situation and it is worthwhile to get the patient to sign a statement to the effect that they recognise the controversial or relatively untried nature of the treatment, and accept that the risks are greater and perhaps even unknown.

For a clinician to say "I obtained informed consent from the patient", or (worse still, as often heard in a hospital setting) "I consented the patient" rather implies that this clinician is in a position to determine the point at which the patient has been given sufficient information in order to make a rational choice. This is almost as paternalistic as giving the patient no information at all, on the time-honoured "doctor knows best" principle. But a patient who is given only some of the relevant facts and considerations regarding a specific procedure, may well be very happy to proceed, while the same patient, if given some additional information, may not. "Informed consent" will always be a misnomer if the patient remains unaware of a further relevant fact that could have influenced their decision.

Similarly, consent cannot be said to be "informed" if the patient misunderstands the information, perhaps because of the words used, or the way in which the information is imparted. At the beginning of the consent process the clinician has the advantage of knowing much more than the patient, about what the procedure involves, about its risks, benefits, limitations, about alternatives and how they compare in each of these respects and also in terms of relative costs. On the other hand, the clinician may also be at a similar disadvantage in knowing relatively little about the patient, and his/her life and personal circumstances.

The clinician must therefore ask the patient the right questions in the right way, at the right time, and needs to listen carefully to the patient's responses, in order to gain an insight into any additional information that this particular, individual patient might require in order to decide whether or not to proceed. Any failure to elicit this information, if it might be material to the patient's decision, is more likely to be used to criticise the clinician, than to criticise the patient for not having volunteered the information without prompting. Patients, after all, may not understand why the information is even relevant, let alone important.

Choosing to withhold certain information – for example, the risks or limitations of procedure A – or declining to mention the option of procedure B at all, is always fraught with dentolegal risks. It will be argued that the resulting 'consent' cannot be valid because it was based on only a selected sample of the information that could and should have been provided to the patient.

Taken to an extreme, one might reach a position where the clinician is placed in a situation where every detail of every procedure, and every possible adverse outcome (however minor or rare) would need to be explained to the patient before starting any treatment. Clearly this would place an impossible burden on the clinician.

24. Kennedy I, Grubb A; Medical Law; Butterworths, London 2000

In non-emergency cases the emphasis should be on ensuring that a patient has sufficient knowledge, in advance of treatment, of:

- The purpose
- The nature of the treatment (what it involves)
- The likely effects and consequences
- Risks, limitations and possible side effects
- Alternatives and how they compare
- Costs.

When patients believe that they have been denied sufficient information they often feel angry, misled or indeed violated or assaulted. These are powerful, destructive feelings that are likely to destroy any relationship of trust upon which consent is founded.

4.12 COMMUNICATION

There is in reality the inter-dependence between the patient and dentist that requires both parties to communicate effectively so that a decision can be made that respects patient autonomy. It is obviously important that the dentist also feels comfortable with proceeding. Effective two-way communication is therefore a cornerstone of the consent process.

Consent is all about communication and a relationship of trust between a patient and a healthcare professional. It relies on a total respect for patient autonomy as far as the patient's capacity will allow. The "best interest" principle, whilst having a valuable role in special needs and emergency situations, needs to be cautiously applied because of the risk of paternalism. These dilemmas are not unusual in dentistry and helpful advice is always at hand from Dental Protection.

5.0 ASPECTS OF CONSENT

It is helpful to consider the main ethical principles of obtaining consent as:

- Informed consent
- Voluntary decision making
- Ability.

5.1 IS CONSENT GIVEN VOLUNTARILY?

In order for consent to be valid, it must be given freely and voluntarily, without any pressure or influence being brought to bear on the patient. This pressure might be from a family member, parent or a health care professional. It is important when seeking to obtain consent that you satisfy yourself that consent has been freely given.

These types of situation will rarely arise in dental practice but when issues of authority and competence confuse the picture, for example in decisions concerning orthodontic treatment of teenagers, you should be considering who is driving the decision to accept treatment. Equally undue pressure should never be exerted on a patient who is unsure about whether to accept a complex, expensive treatment plan. They should be given all the alternatives, and plenty of time to think about their choice prior to starting treatment.

5.2 GENERAL ANAESTHESIA AND SEDATION

When receiving treatment under general anaesthesia or sedation, the patient is temporarily deprived of their capacity (see above) to give a valid consent to treatment. This makes it all the more important that they understand what is proposed in advance of the treatment because it will not be possible to refer to them once treatment is under way. It is also undesirable for the consent process to be carried out immediately prior to the administration of the anaesthesia or sedation, because patients are likely to be preoccupied with or anxious about what lies ahead. Ideally, the consent process should take place at a prior visit, giving the patient time to reflect upon the information provided, and to raise any further questions when they arrive for the procedure to be carried out.

As sedation and general anaesthetic carry with them additional risks, the Dental Board of Australia would require that a valid consent to treatment be obtained, and confirmed **in writing**²⁵ by the patient (or parent) prior to carrying out the treatment. The dentist must himself (or herself) have explained to the patient the treatment proposed, the risks involved in the treatment, and any alternative treatments. All the procedures involved in the anaesthesia/sedation, and in the dental treatment itself, must be explained to the patient. The onus is on the dentist to ensure that all necessary information and explanations have been given to the patient or parent / guardian, either by the **dentist** or by the anaesthetist. It is not acceptable for these explanations to be given by a member of the practice staff.

But providing treatment for a sedated or anaesthetised patient can raise other complications where consent is concerned. In the middle of treatment you notice that there is a cavity on an adjacent tooth to the one that you are treating. Do you fill it to avoid the need for further sedation or leave it and run the risk of the patient being inconvenienced? Does it make a difference if the patient has travelled a great distance for treatment? These are questions that are difficult to answer other than by saying that it depends upon the patient. The “best interests” consideration needs to be weighed carefully against the question of patient autonomy and choice, bearing in mind the fact that some patients might be more than happy for a clinician to proceed whilst others would want the opportunity to influence and to take a specific decision in relation to a specific further item of treatment.

In some cases one could pre-empt this by discussing such possibilities with a patient in advance of treatment – but unforeseen circumstances can always arise. It is the classic dilemma of paternalism against autonomy and there is no “one size fits all” answer.

25. Code of Conduct: March 2014 at www.dentalboard.gov.au

5.3 CONSENT FORMS

Many dentists hold the firm, but mistaken, belief that they have secured proper consent to dental treatment by obtaining the patient's signature on a consent form. The fact that a patient has signed a form does not mean that the treatment proposed has been understood or accepted, and the quality of consent can never be determined solely by a signature which may truly "not be worth the paper it is written on". What matters more is obviously whether or not the consent has been properly obtained, by understanding and applying the principles of competence, information and authority as outlined above.

Written consent forms, especially those of the "I give my consent to any treatment" variety, are often worthless, if insufficient consideration has been given to the above factors. More important than a signature on a consent form is a properly documented patient's record, which show clearly that all the necessary pre-treatment steps have been taken, including explanations and agreements.

The Dental Board of Australia requirement is that a practitioner document 'consent appropriately, including considering the need for written consent in procedures which may result in serious injury or death'.²⁶ This position is expanded upon by the ADA guideline for consent for care in dentistry as; Consent may be given in writing, orally or by conduct. In most routine dental examinations and treatments the patient's consent is obtained verbally. However, where the proposed treatment involves complex or invasive procedures, anaesthesia or sedation, significant expense and/or is of an elective or cosmetic nature, good professional practice warrants the use of a signed written consent form to document the process of consent and confirming the patient's agreement to the proposed treatment. A signed consent form does not, by itself, provide conclusive proof of a legally valid consent. Evidence of the dentist's usual practice, supported by appropriate practice records may be required.²⁷

5.4 WARNINGS

A prerequisite of obtaining consent from a patient is a full exchange of information regarding any risks, drawbacks and limitations of the proposed treatment. It is important to be able to demonstrate that any appropriate warnings were given, and here the most valuable information would be a carefully made entry in the patient's record and/or a warning/advice sheet. If the latter is an integral part of a written consent form signed by the patient (with a copy retained by the patient), then so much the better.

Dental Protection is often asked by members why we do not publish "approved" consent forms that include suitable for use in various situations and circumstances. Such requests fail to recognise the broader issues raised throughout this document. For us to provide such consent forms would imply that to obtain the patient's signature on such a form would be a valid consent; a misapprehension which we are keen to avoid. We are keen to emphasise that consent is essentially a process of communication, and of a transfer of knowledge and understanding from dentist to patient. The value of clinical records and consent forms is dependent upon the extent to which they document and detail that exchange of information.

We have, however, contributed to the creation of consent protocols (checklists) which are available from a commercial source (Admor) and we would be happy, in any event, to offer any member our views on any proposed information/advice sheets and/or proposed consent forms which a dentist was planning to use.

26. Code of Conduct, page 11 3.5 Informed consent, www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

27. See 23

6.0 CONSENT CHECKLIST

The patient should be aware of the purpose, nature, likely effects, risks, and chances of success of a proposed procedure, and of any alternatives to it. The fact that a patient has consented to a procedure on one occasion, does not create an open-ended consent which can be extended to subsequent occasions. Consent must be obtained for specific procedures, on specific occasions. Ask yourself:

- Is the patient capable of making a decision? Is that decision voluntary and without coercion in terms of the balance/bias of the information given, or the timing or context of its provision?
- Does the patient actually **need** the treatment, or is it an **elective** procedure? If an elective procedure, the onus upon a clinician to communicate information and warnings becomes much greater.
- What do I think will happen in the circumstances of this particular case, if I proceed with the treatment? Have I communicated this assessment to the patient in clear terms? Can I give an accurate prediction? If not, is the patient aware of the area(s) of doubt?
- What would a reasonable person expect to be told about the proposed treatment?
- What facts are important and relevant to this specific patient? *(If I don't know, then I am probably not ready to go ahead with the procedure anyway).*
- Do I need to provide any information for the patient in writing? Has the patient expressed a wish to have written information? *(Am I relying upon commercial marketing material produced by manufacturers and/or suppliers? If so, is this information sufficiently balanced in the way it is presented?)*
- Do my records accurately and sufficiently reflect the details of the communication process? Will they allow me to demonstrate – perhaps many months or years from now – what information was given to the patient, on what terms, and what was said at the time?
- Does the patient understand what treatment they have agreed to, and why? Have they been given an opportunity to have any concerns discussed, and/or have their questions answered?
- Does the patient understand the costs involved, including the potential future costs, in the event of any possible complications?
- Does the patient want or need time to consider these options, or to discuss your proposals with someone else? Can you/should you offer to assist in arranging a second opinion?
- If you are relatively inexperienced in carrying out the procedure in question, is the patient aware of this fact? Are they aware, (if relevant) that they could improve their prospects of a successful outcome, or reduce any associated risks, if they elect to have the procedure carried out by a specialist or a more experienced colleague?
- If the technique is relatively untried or of an experimental nature, has the patient been made aware of this? Included here are any procedures for which the evidence base is limited or absent.

7.0 SUMMARY

1. First and foremost, 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 yourself 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) regarding the points raised at 2 (a) (b) (c) (d) above. 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 yourself 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 of The Dental Board of Australia.
7. Keep good and careful records of all matters concerning the question of consent.

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