



Consent to dental treatment

The principles and their application

INFORMATION FOR IRELAND

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1.00 Introduction

A patient's valid consent to investigations or treatment is a fundamental aspect of the proper provision of dental care. Without valid 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 to the Dental Council on matters on professional ethics and conduct.

It is self-evident, therefore, that every practising dentist, therapist and hygienist 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.

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

- What does the patient or the patient's carer need or want 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 European Convention on Human Rights Act 2003 came into force in 2003, putting into effect in Irish Law, the European Convention of Human Rights. Courts are expected to take into account case law from the European Court of Human Rights in Strasbourg as well as Irish Law. An understanding of the law concerning consent must bear in mind the relevant articles which might be invoked in medical law cases, notably Article 2 (protection of right to life); Article 3 (prohibition of torture, inhuman or degrading treatment or punishment); Article 5 (right to liberty and security) Article 8 (right to respect for private and family life) and Article 9 (freedom of thought, conscience and religion).

These Articles may seem somewhat distant from dental practice but a dispute about consent to treatment or the right to withhold or withdraw consent, might involve consideration of a number of these Rights.

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]

2.00

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 Ireland, 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. Ireland 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 in the UK 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 Afshar*², 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 at 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!

² *Chester v Afshar* [2004] UKHL 41

There is no doubt that the case of *Chester v Afshar* will be cited in future cases in the Irish courts relating to consent to treatment. For the moment though the Irish law remains as set out in the case of *Geoghegan v Harris* which is dealt with further below. It is however arguable that the *Afshar* decision may persuade our courts to accept that there are exceptional cases where to adhere to a strict interpretation of the rules of causation would cause an injustice.

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

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.

2.01

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.

2.02

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.

3.00

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.

On the subject of children, dentists should note that a person is an adult at common law from the age of 18. Statute however recognises 16 and 17 year olds as having the capacity to consent to dental treatment on their own behalf. This provision is housed in Section 23 of the Non Fatal Offences against the Person (NFOAP) Act 1997 which states that:

1. The consent of a minor who has obtained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent would constitute a trespass to his/her person, shall be as effective as it would be if he/she were of full age and where a minor has by virtue of this Section given an effective consent to any treatment, it shall not be necessary to obtain any consent for it from his/her parent or guardian.
2. In this section “surgical, medical or dental treatment” includes any procedure undertaken for the purpose of diagnosis and this Section applies to any procedure which is ancillary to any treatment as it applies to that treatment.

Despite the fact that the NFOAP Act is in fact a criminal statute, most commentators treat Section 23 as one of general application enabling 16 and 17 year olds to consent to treatment. One point which is worth noting is that Section 23 confers a right to consent to treatment only; there is nothing in the legislation to say that 16 and 17 year olds have the right to refuse treatment. This point has yet to be tested.

Obviously parental consent is required for 16 and 17 year olds who lack mental capacity.

Dealing with minors under the age of 16 of course raises the issue of “Gillick competence”. This mature minor rule developed in England has yet to be engaged in any meaningful way in Ireland. There is no statutory provision or case law dealing specifically with the mature minor’s ability to consent to treatment. The preponderance of legal thinking is therefore that under 16’s in Ireland have no capacity to consent to treatment.

Matters are made more complex in this jurisdiction because of the special position of the family recognised in Article 41 of the Constitution which sets authority for decisions resting to the family within the family.

In *North Western Health Board v WH*,³ the Supreme Court found that in most circumstances the welfare of a child is best served by deferring healthcare decisions to that child’s parents. The Court did note that there would be circumstances where, in the face of a grave threat to the welfare, health or life of the child, a Court would displace the decision making authority of the parents.

It should be noted that the minor in the WH case was a very young child and the dispute was between the health board and the parents. This case is therefore distinguishable in cases where a minor wishes to assert his or her own rights or wishes the Court to vindicate his rights against his parents and where the treatment the minor is seeking is consistent with his best wishes. It is not clear how a Court would deal with such an issue and this issue has not arisen before the Judiciary to date.

It is worth noting that quite recently the Law Reform Commission has expressed the view that Irish law should be changed to allow for consent to treatment by the under 16’s.⁴ In its report entitled “Children and the Law... Medical Treatment”, the Irish Law Reform Commission provisionally recommended that 14 and 15 year olds be regarded as capable of giving consent to treatment provided that they have the capacity to understand the nature and consequences of the treatment and subject to a number of conditions. These conditions include the requirement that in the opinion of the practitioner the patient understands the nature and the consequence of the proposed treatment, that the practitioner considers the best interests of the patient and that the practitioner encourages the patient to inform his or her parents or guardians.

Therefore although it appears that change may be on the way, as the present law stands a child under the age of 16 is incapable of giving or withholding valid consent to treatment. In the absence of any judicial order or statutory provision to the contrary, it would be our advice that dentists ensure that consent is secured from the parent/guardian prior to the provision of treatment to minors aged under 16.

3 2001 3IR 622 Childcare Amendment Act 2007, Section 43(a)

4 Children and the Law...Medical Treatment LRC CP 59 - 2009

4.00 Authority

4.01 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.

4.02 Children

The subject of children is dealt with in further detail above in paragraph 3.00 and it is advised that dentists ensure that consent is secured from the parent/guardian prior to the provision of treatment to minor aged under 16. Understanding who holds parental responsibility is not always straightforward. If difficulties arise with determining parental consent, caution is advised and consideration should be given to the merit of withholding treatment if doubt exists.

All mothers, whether married or unmarried, have automatic legal guardianship of their child. A child's father has legal guardianship of his child if he is married to the child's mother either before or after the birth of the child. A father who is not married to the child's mother can be appointed as a joint guardian of the child with the consent of the child's mother or alternatively through a Court application.

Other people may gain parental responsibility by Court Order or by being appointed guardians upon the death of the parents. Both testamentary and court appointed guardians can make decisions on behalf of a child.

Foster carers can consent to urgent medical for a child and ancillary treatment although in accordance with a Department of Health & Children Circular, it is generally advised that for non urgent treatment, consent should be sought from the child's natural parents.⁵

If the child is the subject to a Care Order, the Health Board can consent to elective treatment in the best interests of the child however depending on the circumstances it may be good practice to consult with the child's parents.

If a child is a Ward of Court, the consent of the Court is needed before the treatment can be carried out except in an emergency where it is permissible to proceed with treatment in the child's best interests.

4.03 The incompetent adult

The Mental Capacity Bill is still pending at the time of writing. In 2008 the Department of Justice published the Scheme of the proposed Mental Capacity Bill and it proposes greater legal protection for a range of vulnerable adults. The definition of capacity set out in the Scheme of the Bill is that the capacity to make a decision means "the ability to understand the nature and consequence of a decision in the context of available choices at the time the decision is to be made". The Bill presumes that a person has capacity and a person should not be treated as unable to make a decision unless all practicable steps to help that person make a decision had been taken without success.

The Bill also includes provisions for the establishment of a guardian board to replace the Wards of Court Office. Under this Scheme it will be possible to appoint personal guardians who will be able to make healthcare decisions on an incapacitated persons behalf.

Until the proposals for a Mental Capacity Bill are agreed and enacted, legal tests regarding capacity largely depend on judicial interpretations of that term. It is generally thought that if a situation were to arise in Ireland today involving doubt as to a patient's mental capacity to consent to treatment, the Court would most likely follow the guiding principles in *Fitzpatrick & Anor v K & Anor*⁶. In this case the High Court ruled

⁵ *Department of Health Consent for Medical Treatment for Foster Children* (6 November 2009) states that foster carers or relatives who have been caring for 5 years or more may be granted a Court Order that authorises them to consent to "any necessary, medical or psychiatrist examination, treatment or assessment with respect to the child".

⁶ *Fitzpatrick & Anor v K & Anor* ([2008] IEHC 104).

that the Coombe Women's Hospital acted lawfully in giving a blood transfusion to a woman, a Jehovah's witness, who refused the treatment after suffering a haemorrhage post birth.

The relevant principles applicable as set out by Ms Justice Laffoy are as follows:

1. An adult has the capacity to refuse treatment, but it is a rebuttable presumption;
2. The patient's cognitive ability must be so impaired that he does not sufficiently understand the nature, purpose and effect of the treatment and the consequences of accepting or rejecting it, in light of all the choices available;
3. The cognitive ability will have been impaired to the extent that he is incapable of making the decision to refuse by reason of the following factors:
4. The patient has not comprehended and retained the treatment information and the consequences likely to ensue from their refusal;
5. The patient has not believed the treatment information, in particular, that death may be the likely outcome;
6. The patient has not weighed the treatment information, the alternative choices and the likely outcomes in the balance in arriving at the decision.
7. The clinician is under a duty to impart information as to the medically advised appropriate treatment and the risks and consequences and the choices available to the patient;
8. The clinician must recognise misunderstanding and misperception of the treatment information, which may be evidence of a lack of capacity. An irrational decision or a decision made for irrational reasons is irrelevant to the assessment;
9. Regard must also be had to the gravity of the decision and the consequences that are likely to ensue.

4.04

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.

The English Medical Capacity Act 2005 requires people to take certain steps to help them assess whether a particular act or decision is in a person's best interests. While this legislation has no force in Ireland, it provides some useful guidance to practitioners.

The English Mental Capacity Act indicates that 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

- Consider if the person is likely to regain capacity (e.g. 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 under a Lasting Power of Attorney or Enduring Power of Attorney made by the person.
 - » Any deputy appointed by the Court of Protection to make decisions for the person.

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.

4.05

Record keeping

A detailed record should be kept of the decision process for assessing the best interests of that person for each relevant decision. 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.

It is worth pointing out that it is the experience of our panel solicitors that in the absence of notes, the Court will generally favour the patient's recollection of events regarding the consent process. It is therefore very important that a detailed record of the consent process is recorded in the patient's chart and the record should of course be accurate and contemporaneous.

4.06

Situations in which a designated decision-maker can act on behalf of someone who lacks capacity

A. Ward of Court

The Wardship system is a legal mechanism for healthcare decision making on behalf of incapacitated patients. An application is made by a solicitor to the Registrar of the Office of the Wards of Court. The formal application is made by way of petition in the High Court by two sworn medical statements. Once a decision is made, a committee is appointed by the Court to take routine decisions regarding the Ward. Certain matters specifically require the Court's approval including consent to medical treatment, other than emergency treatment which can be provided without the Court's leave.

B. Enduring Powers of Attorney

The Powers of Attorney Act 1996 allows a person to appoint another person to take "personal care decisions" on his behalf in the event that the donor loses capacity. However the act does not envisage that these personal care decisions specifically include healthcare decisions.

C. Advance Care Directives

An Advance Directive is a set of instructions detailing how patients wish to be treated in the event of certain circumstances arising in the future and if, at the time of those circumstances arising, the patient is unable to consent (or withholds consent) himself. To date, advance directives have not been challenged in an Irish Court and their legal status remains uncertain. The weight of Irish case law however supports respecting the individual's right to self determination in healthcare decision making. Early 2012 saw the introduction

of the Advance Healthcare Decisions Bill 2012 which is a welcome development in this area of legal uncertainty in Ireland. The Bill, if enacted, will provide the first legal framework to facilitate the making of Advance Care Directives in Ireland and provide for their effect.

D. Mental Capacity Bill

The Scheme of the Bill provides limited means by which adults can plan for their future while they still have capacity including future healthcare. The Scheme of the Bill provides for the appointment of a substitute decision maker known as a “personal guardian” who is bound to act in the person’s best interests and may be conferred with the power to take decisions in relation to property affairs as well as personal welfare. As outlined above, the Scheme of the Bill also defines capacity for the first time as the ability to understand the nature and consequence of a decision in the context of available choices at the time the decision is to be made. Capacity will be presumed until the contrary is proven and will no longer be determined in relation to decisions generally but in relation to a particular decision at the time that it is to be made.

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 dento-legal advisers at Dental Protection.

4.07

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 Ireland the case of *Geoghegan v Harris* involved and upheld the application of the reasonable patient test as opposed to the clinician centred or “Doctor knows best” approach in respect of the disclosure of information. In this case the patient claimed that he was not warned by the dentist that there was a remote risk that he would suffer chronic neuropathic pain as a result of having dental implants. He argued that had he been properly warned he wouldn’t have undergone this surgery. In concluding that there was an obligation to warn of this risk, it was held that there is an obligation on a dentist to warn of material risks of which the reasonable patient would wish to know. Furthermore it held that the dentist should disclose all risks that the reasonable person in the position of the patient would wish to know and any other risks to which the particular patient attaches importance.

In this case the Court first applied the objective test and concluded that a reasonable patient, standing in the shoes of Mr. Geoghegan would have gone ahead with the procedure. The Court then applied the subjective test and concluded that on the balance of probabilities, Mr. Geoghegan himself would have gone ahead with the procedure had he been warned of the risk of chronic neuropathic pain. Mr. Geoghegan therefore lost his case on the issue of consent.

It is clear from the *Geoghegan* case that the extent of disclosure required places an onus on the dentist to warn of known and foreseeable complications of a carefully carried out procedure. It was accepted in the *Geoghegan* case that the risk of neuropathic injury was less than 1% however as it was a known and foreseeable risk, it should have been disclosed to the patient.

The Supreme Court firmly endorsed the patient centered approach set down in the *Geoghegan* case in the case of *Fitzpatrick v White*⁷ in 2007. The Supreme Court held as follows:

1. If there is a significant risk which would affect the judgment of a reasonable patient, then there is a duty to warn of it. A significant risk is interchangeable with material risk.
2. A patient has a right to know and the practitioner has a duty to warn of all material risks associated with the proposed form of treatment.
3. A risk may be seen as significant/material if a reasonable person in the patient’s position if warned of that risk would be likely to attach significance to it.

In light of the Supreme Court endorsement of the patient centered approach, it must now be considered settled law that the existence of the duty of disclosure is beyond doubt and the standard of disclosure is that set out in *Geoghegan* in 2000.

It is also worth noting that the Irish Courts have held that more rigorous disclosure is required in circumstances

⁷ 2007 IESC 51

where the patient is undergoing an elective form of treatment. In the case of *Walsh v Family Planning Services*⁸ the Court stressed the need to observe a stricter standard of disclosure in cases where elective treatment is involved. It therefore follows that elective surgery requires a very high degree of disclosure.

In order for a patient to succeed in a case alleging a lack of valid consent, he or she must prove firstly that he or she has suffered an injury that has made them worse than they would have been had the procedure not been performed and secondly that the injury is the materialisation of the undisclosed risk and thirdly that if he or she had been informed of the risk they or a reasonable patient would not have consented to the procedure.

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 patient⁹. 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.

4.08

Material risks

In an Australian case (*Rogers v Whitaker*)¹⁰, 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” i.e. 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.

8 1992 11R496

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

10 *Rogers v Whitaker* (1992) 109 ALR 625-631 [1993] 4 med LR 79-82 (High Court of Australia)

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 post-operative 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.

The Irish Dental Council's Code of Practice relating to: Professional Behaviour and Ethical Conduct Professional and Dental Ethics Code states that; "We recommend that you give an estimate of costs in advance and in writing. If the estimate needs to be revised as treatment progresses, you should give a full explanation of the revised costs as early as possible".¹¹

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.

The Dental council's code of Practice relating to: Professional Behaviour and ethical conduct states that; "if you are proposing a new or untested treatment for a patient that does not have a sound evidence base, you must tell them the treatment is new and talk through the risks associated with it".

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.

4.09

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.¹¹

¹¹ Dental Council's Code of Practice regarding: Professional Behaviour and Ethical Conduct, para 6

Patient (A) has a fully erupted lower third molar, with the pre-operative 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.

4.10

“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.

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”¹² 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.

¹² Kennedy I, Grubb A; Medical Law; Butterworths, London 2000

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 dento-legal 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.

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.

4.11

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 corner stone 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.

5.00 Aspects of consent

The Dental Council often becomes involved in various matters of consent, as ethical issues which reflect upon the professional conduct of a dentist.

The Dental Council's Code of Practice relating to: Professional Behaviour and Ethical Conduct states that; "You must get the informed consent of your patient before you begin any treatment. You must obtain verbal or written consent, including consent to treatment costs, before starting treatment. Getting written consent is recommended when the patient is undergoing extensive treatment. You must get written consent if the treatment is being carried out under sedation or general anaesthesia. You must get the consent of a parent or guardian for a patient under 16 years of age. This is required by law. We recommend, though, that you talk to a child or young adult about their treatment and give them enough information to help them be part of the consent process.

If you believe that an adult patient does not have the mental capacity to give informed consent, you should reach an agreement about treatment with the person who is closest to the patient – for example, a relative or carer.

This agreement with a third party has no legal basis under current Irish law. The legal position around consent and vulnerable adults requires legislation. But in exercising a duty of care to your patient, you must, at all times, act in the patient's best interests.

If it's appropriate, you may look for a second opinion before you begin treating an adult patient who you believe to have reduced capacity".¹³

The informed consent of the patient or parent or guardian in the case of a person under 16 years of age should be received before any procedure is commenced. It should be noted that persons under 16 years of age can validly withdraw consent given by a parent/guardian. Consent can be implied, oral or written. Written consent is recommended when extensive treatment is undertaken and is essential when general anaesthesia or sedation is to be administered.

5.01 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.

5.02 General anaesthesia and sedation

The Dental Council takes an active interest in matters relating to consent, as an ethical issue which reflects upon the professional conduct of a dentist.

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.

¹³ Dental Council's Code of Practice regarding: Professional Behaviour and Ethical Conduct, para 7

The Dental Council has produced a Code of Practice Relating to the Administration of General Anaesthesia and Sedation and on Resuscitation in Dentistry. This can be found on the Dental Council's website, www.dentalcouncil.ie. The Code makes it clear that prior to the administration of general anaesthetic/sedation, the procedure including potential risks, should be fully explained to the patient and/or parent/guardian and written consent must be obtained.

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.

5.03

Private or Dental Treatment Services Scheme?

The Dental Treatment Services Scheme is provided by the Department of Health and children and enables GMS patients to obtain free specified dental care from contracting private practitioners or Health Board Clinics. As part of the consent process, it should be explained to patients whether they are being accepted for treatment under the Dental Treatment Services Scheme or as a private patient. Patients should be made aware of the limitations of treatment available under the DTSS and informed of the options open to them.

Dentists are encouraged to avoid misunderstandings by giving the patient a written treatment plan and estimate, and obtaining the patient's agreement to these terms in writing. The Dental Council Code of Ethics requires an estimate of the cost of treatment options to be given and agreement reached before treatment is commenced and recommends that a written estimate be provided.¹⁴

5.04

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.

¹⁴ Dental Council's Code of Practice regarding: Professional Behaviour and Ethical Conduct, para 6

5.05

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, created some consent protocols (checklists) which may assist in taking the patient through the consent process. 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.

6.00

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.

7.00

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 (see appendix) 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 Council.
7. Keep good and careful records of all matters concerning the question of consent.

**Dental Protection Limited**

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