A PRACTICAL GUIDE

Better Consent

The issue of consent causes a great deal of stress and misunderstanding by health practitioners in general and perhaps dental practitioners in particular. **Patients cannot validly consent to treatment they do not understand**.

This happens frequently in complaints and notifications by patients.

If the consent process is followed and clinical notes are accurate, many such issues would not be the subject of the complaint.

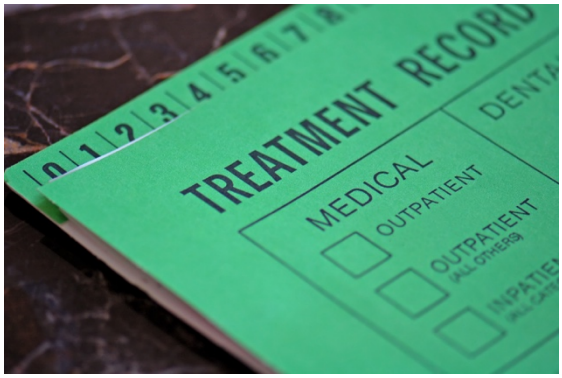
If a patient understands what is being done and has had warnings as to risks in writing and has a costs disclosure, then most of the work is done in this regard.

There are a number of types of consent that need to be considered by practitioners when they are advising people as to courses of treatment. These are broadly

1. consent to assault or trespass
2. consent to treatment that the patient understands
3. consent to the risks of treatment including the failures of the treatment
4. consent to treatment where options for treatment have been provided including referral to another practitioner
5. consent to the cost of treatment

Unfortunately the Tribunals and Boards use the words 'informed consent" which is arguably not an appropriate term, having an origin in the United States, but consent for all of these subtypes is an issue of judgment by both practitioners and patients in the scheme of things although ultimately this can fall to a Court.

In other words patients and dentists may have a different view on whether valid consent exists. But patients will only complain or allege a failure to have been given valid consent **where they believe they did not understand what was being done, why it was being done and that they did not agree to that treatment**.



When this occurs the dentist may have to answer to a Board, Council Tribunal or Court.

VALID CONSENT (FULL RELEVANT DISCLOSURE)

Valid consent exists for a particular procedure where a given patient understands the nature, the costs, the risk of a particular treatment and where they have been given an opportunity to ask questions in relation to all an any aspects of the treatment in this regard and further where these questions have been answered truthfully and any other aspects or information that is relevant has been disclosed.

Consent to assault or trespass only arises of for example if a dentist were commencing treatment on a patient who did not agree to any treatment, or had only agreed to treatment that was very different to what had been agreed. This might occur where a tooth was extracted without the patient knowing when they were having another restoration done.

Practitioners who can be empathetic and place themselves in the position of the patient will generally be able to do this naturally.

Dentists should consider what they would expect if they were being treated by a specialist for something that was expensive ?

ROGERS AND WHITTAKER

Rogers v Whittaker is the Australian case which famously says that the law should recognise that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if in the circumstances of a particular case a reasonable person in the patient's position if warned of the risk would be likely to attach significance to it or if 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.

The test is therefore **a two limb test**.

The first limb relates to a reasonable person attaching significance to the risk.

The second limb catches patients who the practitioner should reasonably be aware would attach significance to that particular risk.

The **material risk assessment** is different for every procedure and every patient so some thought needs to be addressed to each case.

Common sense suggests that there is a higher duty to disclose to a patient if the patient is voluntarily bringing him or herself into an area of risk without necessity so it would seem even more necessary to disclose the potential risks involved. The less life threating, **the more elective and the more optional the proposed treatment is, the more likely that any risk should be disclosed.**

A therapeutic privilege can be stated that a doctor (dentist) may withhold information where disclosure would be adverse to the patient's interests. This was reduced significantly as being effective in the case of *Rogers v Whittaker* and in dentistry it is hard to think of a common example where it would be appropriate.

A dental practitioner presently cannot be expected to warn of a risk of which there is either no general knowledge by the profession as a whole or that the incidence is comparatively miniscule.

But these precautions in determining what risks of which one should warn should be noted .

An injury with a permanent nature such as a paraesthesia will always be material if it is foreseeable. Percentage risk is not the solely determinative factor as to materiality of risk.

CONSENT IS A PROCESS

If a practitioner obtains consent, it is not permanent, patients may verbally withdraw consent at any time. It is therefore good practice to inform before you perform. That means ask patients constantly " Is it OK if…" or "Are you happy for me to ?"….

HOW DO I GET CONSENT ?

The dentist must consider the risks that are material and provide documents for the normal risks of all procedures they perform and these can be on a website, in writing or both.

The best way to satisfy yourself that you have appropriately obtained consent – informed or otherwise- is to be aware of the issues and follow a process.

1. Does the patient understand the **nature of the procedure**- time taken, and the nature of what is done and how long it will last. Ask them !
2. Have you provided **options of other treatment** and does the patient understand that ? Evidence this in writing in the clinical notes.
3. Has the patient received a **costs estimate in writing** ? Print it out and ask them if they have any questions.
4. Are you satisfied that you have explained **normal sequelae of the treatment** ? It ought to be evidenced by an information sheet.
5. Are you satisfied that you have explained **abnormal sequelae of the**

treatment ? It ought to be evidenced by an information sheet.

6. Have you therefore covered **all the material risks** that you would warn of ?
7. Has the patient through the answers to your questions **demonstrated that they understand** the nature costs and risks of the procedure ?
8. Have you **asked enough questions of the patient** and received answers to be sure that the disclosure and understanding is complete ? This should be evidenced in writing where appropriate.
9. Is the treatment of such a nature that **a written consent form** is appropriate (for example implants, orthodontics, wisdom teeth extractions, surgery, complex crown and bridge.)
10. If the treatment is of such a nature that a written consent form is appropriate, then **have you offered referral** ?
11. Has all of the above **process been recorded** to some reasonable level ?

SOME OTHER COMMENTS

Notes of warnings should be issued and documented with a staff member present. For example when removing lower wisdom teeth warnings of temporary and permanent paraesthesia of lip and tongue and possible taste and salivary gland effects should be routinely given.

Material risks should be communicated to patients in a combination of written and spoken word.

The communications should **not be contrary** – they should be complementary or reinforce each other. Any written warning documents that are printed such as pamphlets should be updated and accord with the practitioner's current practice and what is verbally communicated to the patient.

Where oral instructions are given they should be **read from a dated form**, a copy of which should be dated and retained so that practitioners have an accurate record of what warnings were given an when they made changes to these practices and warnings.

A poor result from some surgery can lead to **psychological problems** and subsequent treatment leading to damages for which a treating practitioner may be liable in the absence of any warning.

Hopefully, if you can think about this and put yourself in the patient's position, you will be good to go.

If you do not, then you may be at risk if a complaint is made by the patient.

Patients will have less basis on which to complain if they have had the same procedure before- particularly with that practitioner.

The more inquisitive the patient, the more time the consent process should take.

The more expensive and complex the treatment, the longer the process ought to take and be evidenced by way of written warnings and written consent.