

Dental Ethics Case 3: Informed consent: risks and benefits of treatment

SADJ July 2010, Vol 65 No 6 p270 - p271

Prof S Naidoo: BDS(Lon), LDS.RCS (Eng), MDPH (Lon), DDPH.RCS (Eng), MChD (Comm Dent), PhD (US). Professor and Principal Specialist, Department of Community Oral Health, University of the Western Cape, Private Bag X1, Tygerberg, 7505. Tel: +27 21 937 3148. Fax: +27 21 931 2287. E-mail: suenaidoo@uwc.ac.za

CASE SCENARIO

A patient attended for extractions under general anaesthetic. There was a discussion about which teeth to remove, however, the patient's abiding memory was that no discussion had taken place about post-operative sequelae and that no warnings had been given about adverse outcomes. Nothing was noted in the records. Following the extractions, the patient suffered nerve damage and subsequently sued for a failure to warn. The dentist suggested that it was his normal practice to warn about such things but he could not recall the particular patient or prove that he warned them of the possible consequences on this occasion.

COMMENTARY

There are two primary duties when providing dental treatment - firstly, the provision of such care needs to be of an acceptable standard and secondly, respect for the autonomy of patients and their right to exercise control over what happens to their body. Before a patient has any treatment, we need to obtain their agreement. This is both an ethical and a legal requirement. It is important that a patient is competent to consent. A competent patient will be able to make a choice based on an understanding of the information given to him/her, of the diagnosis, the procedures to be carried out and its consequences, both as regards prognosis and risks. On the basis of this information, competent patients will be able to reason about - to weigh up - the proposed treatment options. The dentist's recommendation is also important. This is especially relevant in our setting in South Africa where the concept of autonomy may not be so fully understood and applied in professional practice. This can be so for many cultural reasons, not least the high and unquestioning value that patients place on the advice of their dentists and the equally unquestioning paternalism towards them that this can reinforce. Hence, in advising our patients, it is essential that we are always motivated by the patient's best interests.

A classic example of a failure to communicate information required for valid consent often arises over the extraction of third molars. Patients and judges in civil claims often use the argument that to attend the dentist for the removal of a third molar is a 'life event' for a patient. The patient will sometimes be able to recall many details including explanations (or lack of them) given by a dentist and include the details of the dentist's mood or attitude. To the dentist the patient is just one of many patients whose wisdom teeth are being removed. From the patient's viewpoint, a minimal risk is still a risk and clinicians have no right to impose it unless there are no options with fewer risks. Any risks which might make a 'prudent' patient refuse treatment should be specifically discussed.

As with any procedure, extraction of teeth carries several risks. Once a diagnosis is made, these risks and other information need to be provided to the patient before consent can be obtained. This is clear from No. 61 of the National Health Act of 2003, Chapter 2 Item 6: "User knowledge":

- Range of diagnostic procedures and treatment options available
- Benefits, risks, costs and consequences associated with each option
- User's right to refuse care and explain implications, risks and obligations of such refusal
- Furthermore, this information must be provided in a language that the patient understands and in a manner that takes into account the patient's literacy level.

It is often impossible to inform patients fully and in detail about all the possible risks and side-effects of a treatment. So just how much should they be told? Clearly, if the potential and known consequences of treatment might keep patients from leading their normal lives, they should be informed about them. In this regard, patients may need more information to make an informed decision about a procedure which carries a high risk of failure or adverse side effects. To the degree that such risks are known, they should be communicated to the patients even if the probability of their occurring is low. Where such risks are not known or are difficult to foresee then patients should be given this information as well. Furthermore, there may be other potential consequences of treatment which may not interfere with the patient's life style. 'Prudent' patients will not be so interested in this information and sensible dentists will use their discretion in deciding what to reveal. But, it is important to note that there is a fine line between the two categories of side effects - those that interfere with normal life and those which are mildly inconvenient - and will often depend on the employment of the patient. Dentists should bear this in mind when deciding what they will and will not attempt to communicate about side-effects with little risk of disability. A practical way of doing so is to ask themselves what they - or their close relatives and friends - should be told were they in the educational, emotional and clinical position of the patient.

Studies have shown that pre-operative patient education, providing coping strategies and/or reasonable expectations regarding the post-operative course can help lessen patient anxiety and decrease pain, complications and recovery time. The quantity of postoperative preparatory information significantly increases pain relief and resultant satisfaction with pain control without increasing analgesic consumption. Furthermore, there is a relationship between communication skills and complaints lodged against health care workers: dentists who are pre-occupied with

procedures or technology, who spend little time talking to patients and who give minimal explanations to patients are at higher risk of litigation. Risk of litigation appears to be related to “patients’ dissatisfaction with their physicians’ ability to establish rapport, provide access, administer care and treatment consistent with expectations and communicate effectively”. However, while it is important to obtain a patient’s informed consent, it is not a panacea for any claims of negligence.

In summary, dentists should always have a frank discussion with patients about all the possible risks and alternatives to the treatment proposed. It is recommended that at the end of treatment planning the dentist should ask the patient to sign a general outline of what has been agreed to and understood including possible adverse events. The treatment plan should always be in writing and as regards private dentistry, should always include a clear statement of the financial costs to which patients are committing themselves. This would show that the duty to obtain consent was taken seriously and recognized by both the dentist and patient.

REFERENCES

1. Beauchamp TL, Childress JF (2001) Principles of Biomedical Ethics, New York: Oxford University Press.

2. Doyal L, Cannell H. Informed consent and the practice of good dentistry. *BDJ* 1995 178: 454-460
3. Doyal L, Cannell H. Whistle blowing: the ethics of revealing professional competence within dentistry. *BDJ* 1993; 189: 95-101.
4. Health Professions Council of South Africa. General Ethical Guidelines for the Health Professions. Booklet 9. Seeking patients’ informed consent: ethical considerations, May 2008.
5. Vallerand WP, Vallerand AH, Heft M. The effects of postoperative preparatory information on the clinical course following third molar extraction. *J Oral Maxillofac Surg.* 1994; 52(11):1165-70.

ACKNOWLEDGEMENT:

With grateful thanks to Prof Len Doyle, Emeritus Professor of medical ethics, St Barts and The London Medical Hospital, Queen Mary, University of London for his erudite and insightful comments.

Readers are invited to submit any ethical queries or dilemmas to Prof S Naidoo, Department of Community Dentistry, Private Bag X1, Tygerberg 7505 or email: suenaidoo@uwc.ac.za and rswane-poel@sada.co.za

Declaration: No conflict of interests was declared

Ethical CEU’s apply to this article