Patient Education & Informed Consent

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Most dentists believe the educated patient is more likely to follow recommendations and, consequently, is more likely to experience a positive treatment outcome. Risk management experts also believe the educated patient is more likely to have realistic expectations about treatment results. Furthermore, the patient education process provides an opportunity for the dentist to develop rapport with patients, which may lessen the likelihood of malpractice claims.

In recent years, the increase in dental malpractice lawsuits alleging lack of informed consent has prompted dentists to reexamine their patient education and informed consent processes.

Patient education and informed consent issues are not exclusive to dental specialists who perform invasive procedures or extensive treatments. Education and consent are also strong components of general dentistry. In assessing education style and procedures, dentists should consider:

- the type of information provided to patients and how it is provided;
- whether formal consent is necessary; and
- whether the patient is able to understand the information and consent to treatment.

Information

Risk management experts recommend providing patients with the following information:

- the diagnosis;
- the proposed treatment;
- what to expect (e.g., pain);
- anticipated benefits of the procedure;
- associated risks;
- alternatives to treatment; and

- the anticipated result if no treatment is provided.

Information should be provided in layperson's terms. For example, many patients may not understand the dental term gingivectomy, but they would understand if someone told them they were having their diseased gum tissue surgically removed.

Which risks should be discussed?
Dentists cannot anticipate every possible risk, nor should they be required to discuss every conceivable risk. Statutes and case law often use the phrase material risks when describing which risks should be reviewed prior to treatment. Material risks are defined as those risks that are most relevant to the patient (i.e., the most common and the most serious). For example, if an oral surgeon knows that a certain percentage of patients will experience an infection after a procedure, it would be appropriate to discuss that risk with the patient. Similarly, if a patient could experience permanent nerve damage as a result of an inferior alveolar nerve block, the risk should be discussed with the patient, even though the percentage of patients experiencing permanent paresthesia is minimal. Dentists should also explain there may be other potential risks, but that the most common and most serious risks are being reviewed with the patient.

When discussing alternative treatments with patients, dentists are not obligated to discuss every possible alternative. Informed consent statutes often use the term "reasonable" alternatives. A dentist should also explain why alternative treatments are not recommended.

In concluding the discussion, dentists should encourage patients to ask questions and then document that the patient was given the opportunity to ask questions. Additionally, the dentist may wish to suggest a referral for a second opinion if the patient appears undecided or if prudence would dictate a second opinion in light of the seriousness of the treatment.

How should pertinent information be supplied?
Information should be provided through discussion followed by written information.

Verbal discussion

The treating dentist should conduct a face-to-face discussion with the patient. This provides the dentist with an additional opportunity to interact with the patient and to strengthen the dentist-patient relationship. Unfortunately, no matter how well the dentist documents the patient education process, much of the discussion component does not get documented in the chart. This is why discussions should be supplemented with written information.

Written information

Dental practices often use patient information sheets or educational brochures to help describe various proposed treatments. When selecting or composing such educational materials, dentists should ensure that the information outlined on page one of this newsletter is included (diagnosis, proposed treatment, anticipated benefits, risks, etc.).

Written educational materials are valuable primarily because they provide excellent documentation of what was communicated to the patient about the proposed treatment. Therefore, dentists or their staff should be sure to document the provision of these materials. Written materials are also valuable in that they allow the dentist to communicate with other family members who may not be present during informed consent discussions. Patients can take educational materials home with them, providing family members with the opportunity to read about the risks and benefits of the treatment. Lastly, written materials are helpful because they reiterate previously discussed information, which may enhance patient comprehension.

Language barriers

Dentists should consider potential language barriers when communicating with patients regarding proposed treatments. Dentists may wish to develop written educational materials in different languages to meet the needs of their patient population. Additionally, they may wish to hire multilingual staff or explore sources for interpreters to assist in patient education discussions.

Consent

Oftentimes, much emphasis is placed on obtaining patients' written consent and less attention is devoted to the educational process. Such emphasis is misplaced. While written evidence of consent is helpful in defending dental

malpractice claims, the informed consent process itself, is far more important than the form. That being said, dentists should evaluate those situations where a consent form may be necessary.

With general dentistry, consent is typically manifested by the patient keeping appointments, receiving prophies and x-rays, and complying with the dentist's recommendations. A written consent form is not necessary each time the dentist proposes a treatment.

Of course, dentists should obtain written consent when contemplating invasive procedures. As an example, written consent should be obtained for extractions. There may also be occasions when noninvasive treatments require the use of consent forms, as in the case of orthodontics.

In deciding whether to obtain written consent, the dentist should evaluate the magnitude of the risk associated with the procedure or treatment. For example, a dentist performing a filling may or may not decide to obtain written consent. On the other hand, a dentist removing impacted third molars should obtain written consent. Of course, in both situations, the dentist should educate the patient about the proposed treatment or procedure, along with its risks, benefits, and reasonable treatment alternatives.

Written consent can be accomplished in one of two ways. Dentists may use procedure-specific consent forms that include the information listed previously in this article—diagnosis, proposed procedure, risks, anticipated benefits, etc. (See the summary paragraph of this article for information on ProNational's sample consent forms.) Alternatively, dentists may develop a shorter, simple statement of consent which refers to the written information already provided to the patient. Consent forms should conclude with a statement that the patient has had an opportunity to have all of his/her questions answered, and that the patient understands he/she may seek a second opinion.

Competency

Lastly, dentists should evaluate whether a patient has the ability to understand the information and to consent to treatment. When evaluating patient competency, dentists

should consider mental status, age, sedation and literacy.

If a dentist believes a patient’s mental status prevents the patient from consenting to treatment, the dentist should inquire as to whether a legal guardian has been appointed, or whether another individual has been given medical/dental power of attorney for the patient. If neither has occurred, the dentist may consider petitioning the local court to have guardianship established.

Dentists should also consider a patient’s age. Most minors cannot consent to treatment except in certain isolated situations provided by state statute (e.g., dental problems associated with pregnancy, etc.). This issue does not affect dental offices as often as it does medical offices.

Obviously, if a patient is sedated, the dentist should not attempt to proceed to educate the patient and obtain informed consent. The patient should be rescheduled for another visit.

Dentists must always consider the possibility that the patient is illiterate. If a patient is illiterate, written educational materials and consent forms are of little value. Again, this is why discussions are so important. The dentist might also consider offering patients educational videotapes to ensure effective communication.

Summary

Patient education and informed consent procedures play an important role in improving patient outcomes, assuring realistic expectations, and enhancing dentists’ relationships with patients. Additionally, a well-established informed consent process may assist in the prevention and defense of malpractice claims. Each dentist’s informed consent process should consider the information provided to patients, take into account the circumstances under which written consent is obtained, and assist in evaluating a patient’s competency to consent to treatment.

ProNational has developed four procedure-specific consent forms: extractions, root canal therapy, periodontics, and orthodontics. If you would like copies of ProNational’s consent forms, please contact Emily Odenwald at 800/292-1036, extension 6228.

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