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Practice Management/ Legal

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What is Informed Consent?

Introduction

All dentists are required to obtain an informed consent from their patients prior to initiating treatment, but when the informed consent process is lacking, often from inadequate documentation, dentists may be exposing themselves to both professional and civil liability. Good practice dictates disclosing only those risks that require disclosure and not those that are highly unlikely to occur. Determining which risks to disclose is a process that involves balancing the nature of the risk, the patient's particular dental situation, the opinion of experts in the field regarding the likelihood of occurrence, and an understanding of how the knowledge of the risk might affect the patient's decision to proceed with treatment. This article aims to provide an explanation of what risks and other information must be conveyed to patients and how best to communicate and document these risks to fulfil the need for informed consent.

The Legal Basis for Informed Consent Law in Ontario

Legislation and precedent-setting medical malpractice cases establish the starting point for Ontario's law on informed consent. Much of this is already well known to dentists via College publications and newsletters, and includes the following points:

- Treatment must only be provided after consent has been voluntarily obtained from a capable individual.[1]
- Consent must include a discussion/information exchange concerning the
  - nature of the treatment (diagnosis and recommended treatment
  - expected benefits of the treatment;
  - material risks and side-effects of the treatment;
  - alternative treatments (if any) that are available; and
  - consequences of not having treatment.[2]
- Health-care providers have a duty to disclose all material, special or unusual risks before treatment.[3]
- Causation depends on whether or not a reasonable person in the patient's particular position, would agree or not agree to proceed with treatment, if all material, special or unusual risks of the treatment were made known to him/her.[4]
- A dentist may avoid civil liability if he/she can prove that the patient would have had the treatment **even** if the health care provider had disclosed the risks.[5]
- A failure to obtain consent is grounds for professional misconduct.[6]

Canadian Case Law on Informed Consent[7]

CASE 1

In an Ontario case involving lingual nerve paraesthesia persisting four years after a mandibular nerve block, the patient claimed that had she known of the risk of permanent numbness, she would not have consented to the treatment (and of course the injection). An expert testified that the risk of paraesthesia after an injection is one in 800,000 injections and is therefore a remote risk about which most dentists do not warn their patients.[8] The court agreed and stated a **test** to be applied in determining if a particular risk warrants disclosure:

> *This court must weigh the seriousness of the risk, the frequency of the risk, what dentists usually convey to their patients about this risk, and the evidence of the academic expert in weighing the detrimental and deterrent effect of conveying the risk of moderately serious discomfort against the risk that patients will refuse treatment that is necessary and without which they may face much greater consequences.*[9]

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CASE 2

A patient claimed against a British Columbia oral surgeon for failing to disclose the risk of possible nerve damage in her lower lip and chin following the extraction of a lower impacted wisdom tooth. The patient testified that she was warned of pain, swelling and soreness, but not of any possible long-term numbness. The Court agreed that the oral surgeon's warning was insufficient on the basis that he himself acknowledged that the roots were in close proximity to the inferior alveolar nerve, but did not warn about the risk of permanent paraesthesia. The deciding factor for the judge in this case was the patient's particular circumstances:

> ***She was suffering no discomfort from her wisdom teeth and they were not acutely infected. In my view, a reasonable person in her position, confronted with a choice between, on the one hand, optional surgery which was unlikely to improve the problem for which she had sought it out, and which carried a five to 10 percent chance of nerve damage and its attendant risks, and on the other hand, not having that surgery and living with the possibility that her wisdom teeth might cause her problems in the future, would most probably have decided against the surgical removal of those teeth.***[10]

Other cases[11] have established that with regard to wisdom tooth extractions, permanent paraesthesia of the inferior alveolar nerve is only a material, special or unusual risk when the roots are known to be impinging upon or near the inferior alveolar nerve canal.

CASE 3

In a leading Supreme Court of Canada case,[12] a **material risk** was defined as being a risk associated with treatment that a reasonable person would attach significance to in deciding whether or not to undergo the proposed therapy. **Special or unusual risks** relate to more serious consequences, even if they are less likely to occur.

CASE 4

During the extraction of a lower wisdom tooth, an Alberta patient suffered a fractured jaw. In this case, the patient signed a written consent form listing the following risks:

- paraesthesia (numbness lip/chin)
- infection
- swelling
- pain
- bleeding
- sinus perforation

Experts testified that the risk of jaw fracture during wisdom tooth extraction was remote and therefore, most dentists do not warn patients of this risk. The Court agreed that there was no duty to warn of the remote possibility of jaw fracture. While this ruling avoids liability for the dentist on the basis of failing to disclose risks, it does not deal with the separate issue of whether or not the dental treatment was negligent.[13]

CASE 5

In a B.C. case involving root canal misadventure, a dentist appealed the lower court's decision that found him negligent for failing to warn the patient of the risk of an endodontic instrument breaking off inside a tooth. The Court of Appeal overturned the lower court's decision and stated:

> ***There was no evidence to support the trial judge's conclusion that the possibility of an instrument breaking or "separating" to use the expert's testimony, during the course of the root canal procedure was a "material risk of which a patient should be warned".***[14]

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STRONG DENTURE
1/3 SQUARE
BLACK AND WHITE

CASE 6

A patient suffering from a TMJ flare-up following impacted third molar extractions claimed that the failure of an oral surgeon to disclose the risk of TMJ symptoms associated with the surgery was negligent, because damage to the TMJ was a material risk associated with this procedure. Based on expert evidence, the court did not agree that TMJ injury is a material, special or unusual risk associated with this type of surgery and therefore ruled that the dentist did not need to warn the patient of any such risk.[15]

Contrary to the cases noted above, some dentists may be overly cautious and disclose every possible risk, however unlikely, believing that this will insulate them from any claim concerning informed consent. However, this approach is not looked upon favourably and is seen as a "blanket" non-specific attempt to cover off any liability rather than a genuine exchange of information. In fact, disclosing very remote possibilities may unnecessarily upset patients and be seen as counterproductive rather than helpful.[16]

How Should You Tell Them

As noted above, the law states that before providing treatment, a dentist must obtain an informed consent. However, the law does not state how this should be accomplished (verbally, written or by a combination of both). Neither verbal nor written consent will guarantee that consent has been obtained. Only when **all** the elements have been conveyed can there be true consent. Further, it is the duty of the dentist to **personally** communicate a diagnosis and obtain the patient's consent to treatment and **these tasks may not be delegated to staff.**[17]

How Can You Prove What You Told Them

Legally, the important aspect of obtaining informed consent is not how you tell the patient the information, but that you can **prove** what you told them. When faced with a complaint involving failure to obtain proper consent, relying on a defence of **verbal consent** is risky.

Documenting the obtaining of informed consent does **not** equate with a chart entry that simply states

ODA SELECT
1/2 HORIZONTAL
4-COLOUR

'informed consent obtained'. Documentation requires that the **details** provided must be specified. For **verbal consent**, this requires making a chart entry indicating that all of the elements of informed consent have been obtained. For example, for the endodontic treatment of a molar, an example of a proper chart entry is:

> ***Discussed diagnosis of irreversible pulpitis, RCT procedure, fees and insurance coverage. The need for RCT was explained (with visual aids). Patient was advised that without RCT, tooth would have to be extracted. Explained that after RCT, patient may experience pain, swelling and tenderness to chewing. Painkillers and/or antibiotics may be required. Explained that the tooth will have a temporary filling and will need a permanent filling and/or eventually a crown. Explained the risk of tooth fracture after RCT has started, especially before permanent filling and crown can be completed. Patient was asked if he/she had any questions and he/she did not. Patient verbally consented to RCT.***

Written consent forms alone **do not** suffice — there must be a corresponding chart entry made that describes the process under which the consent form was signed. For the extraction of a wisdom tooth (in addition to the use of a signed consent form), an example of a proper chart entry is:

> ***Prior to treatment, the patient was given a consent form to read about wisdom tooth extractions, which described the procedure, benefits, risks, side-effects and complications of surgery and was asked if he/she had any questions. The patient did not have any questions and signed the form in my presence. A copy was retained in the chart.***

Summary

The law concerning informed consent requires that dentists in Ontario:

- ensure they understand the elements inherent in the obtaining of an informed consent;
- ensure they communicate the required information to their patients before initiating treatment, and most importantly
- ensure that in obtaining an informed consent, these discussions are properly documented in the patient's chart. OD

References

1. *Health Care Consent Act*, 1996, S.O. 1996, Chapter 2, Schedule A, section 10(1) and 11(1).
2. *Ibid* at section 11(3).
3. *Hopp v. Lepp* [1980] S.C.J. No. 57 (Supreme Court of Canada).
4. *Reibl v. Hughes* [1980] S.C.J. No. 105 (Supreme Court of Canada).
5. *Ibid.*
6. Ontario Regulation 853/93 (Professional Misconduct) s. 2.7 under *Dentistry Act, 1991.*
7. Canadian case law from jurisdictions outside Ontario carries significant legal weight in Ontario due to the similarity in legislation, rules and guidelines amongst all provinces.
8. *Practice Alert* in *RCDSO Dispatch* (Summer 2005) discussed the "advisability" of dentists using four percent local anesthetic solutions due to a reported higher incidence of paraesthesia associated with mandibular block injections. This claim has been challenged by a distributor of Articaine in a letter published in the Fall 2005 issue of *Dispatch.*
9. *DeFerrari v. Neville* [1998] O.J. No. 3571 (Ontario Court of Justice – General Division).
10. *Rawlings v. Lindsay* [1982] B.C.J. No. 209 (B.C. Supreme Court).
11. *Parkinson v. MacDonald* [1987] B.C.J. No. 785 (B.C. Supreme Court).
12. *Supra* note 3.
13. *Carter v. Higashi* [1993] A.J. No. 915 (Alberta Court of Queen's Bench).
14. *Curtenau v. Kapusianyk* [2001] B.C.J. No. 1855 (B.C. Supreme Court).
15. *Constantini v. Wakeham* [1991] A.J. No. 906 (Alberta Court of Queen's Bench).
16. *Schinz v. Dickson* [1984] B.C.J. No. 2748 (B.C. Court of Appeal).
17. *Dentistry Act, 1991*, S.O. 1991, Chapter 24, section 4 and *Documenting Informed Consent*, Dispatch Oct/Nov 2003.