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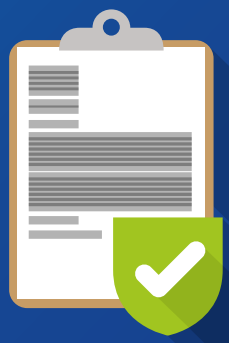
CONSENT

SCOTLAND



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CONSENT TO DENTAL TREATMENT

THE PRINCIPLES AND THEIR APPLICATION

CONTENTS

1.0 INTRODUCTION

A patient's informed consent to investigations or treatment is a fundamental aspect of the proper provision of dental care. Without informed 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 made under the NHS Complaints Procedure, and complaints to the General 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. In 1990 The Department of Health in England, in its advice booklet on obtaining consent, has defined consent as:

"The voluntary and continuing permission of the patient to receive a particular treatment. It must be based upon adequate knowledge of the purpose, nature and likely effects and risks of that treatment, including the likelihood of its success and any alternative to it". [2]

The current version of the Department of Health's guide to consent was revised in July 2009.[3]

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

- What does the patient or the patient's carer need 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 Human Rights Act 1998 came into force in October 2000, putting into effect in English Law, the European Convention of Human Rights. Human rights legislation had already, by that stage, been incorporated into Scots law by the Scotland Act 1998. Courts are expected to take into account case law from the European Court of Human Rights in Strasbourg as well as Scots 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. *A Guide to Consent for Examination or Treatment*, Department of Health, 1990. acc HC(90)22
3. Reference Guide to Consent for Eamination or Treatment, Second edition 2009, Department of Health London 2009

2.0 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 in the UK, 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 the UK, 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. The UK, in particular, 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 medicolegally.

A landmark legal case (described below) 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[4], 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).

"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 as 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 and as this was a House of Lords decision, it also applies in Scotland. 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!

4. Chester **v** Afshar [2004] UKHL 41

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.

An example in dentistry might be a teenage child who presents with his / her parents for orthodontic treatment. The parents clearly want the child to have orthodontic treatment for cosmetic reasons and the orthodontic treatment may even be judged to be in the child's best interests by both parents and the treating practitioner(s). The child may have a malocclusion that is severe and would greatly benefit from the proposed treatment. But notwithstanding the best of intentions on the part of the parents, the child may still feel coerced into having treatment which goes against his / her own wishes as regards their own body. In many countries parents may even have a legal right to make a decision on behalf of a child, notwithstanding a child's personal preferences.

If one examines consent purely from the point of view of autonomy then any consent obtained in that situation may not be valid if the child has not made the decision with his / her own free will. Even if the child agrees, a clinician may find it difficult to ensure that there is no undue influence being placed upon the child in reaching that decision. We will discuss this further at 3.0 (page 7).

2.1 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.

2.2 RESPECT

This brings together the ethical and human dimensions of consent (see opening section 1.0), and can be summarised as dealing with patients as we would wish to be dealt withourselves, 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.

3.0 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, many dentists mistakenly assume that because a child is allowed to sign a NHS form at age 16 then s/he is therefore competent to consent (and indeed, is giving a valid consent in the very process of signing the NHS form). Such assumptions are misplaced, and reflect a lack of understanding of the underlying principles.

Firstly, a signature on a NHS form is not consent at all, but merely a request to be treated within the NHS, rather than on a private basis.

Secondly, most children eventually reach an age where they can grasp relevant facts about their body and about proposed treatment to their body. A few children are never, even when adulthood is reached, capable of properly understanding the information given to them and then must therefore be considered incapable of giving consent.

In order to protect children, laws exist in many countries defining the age at which children can normally be considered capable of making their own decisions in this respect. In England and Wales, the relevant legislation is to be found within the Family Law Reform Act 1969. This act permits an individual of 16 or over, and of sound mind, to give a legally valid consent to dental treatment; it does not preclude children under 16 from also giving consent.

In Scotland, the situation is governed by the Age of Legal Capacity (Scotland) Act 1991, which gives legal capacity to a person over 16 years to enter into a transaction, including the giving of any consent having legal effect.

Many readers will be familiar with the *Gillick*[5] case in England, which related to the provision of contraceptive aids to girls under 16 years of age without parental consent. As a result of this case, the view is generally held that children, if they can fully understand the proposed treatment, can give consent to that treatment.

In Scotland, persons under 16 years of age can also consent to medical or dental treatment. The Age of Legal Capacity (Scotland) Act 1991, Section 2 (4), provides that:

"A person under the age of 16 years shall have the legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment."

A child of any age can, in theory, therefore give valid consent if s/he is considered by the practitioner to understand the nature of the proposed treatment. The capacity to consent under the 1991 Act is fairly wide ranging, expressly covering both procedures and treatment. For a child who does not have capacity to consent to treatment under the 1991 Act, the law is governed by the Children (Scotland) Act 1995.

Dentists should always try to confirm that both the child and the parent understand the treatment to be given. Even in cases where it is believed that the child may be capable of giving consent which would negate the need to obtain parental consent, it is still wise to try to seek the child's permission for a discussion with the parent to confirm their agreement.

If a parent is not available when children under 16 years of age are examined, then extreme caution is advised. A few years ago, the Court of Appeal in England, in the case Re-R[6], decided that where a child under 16 refuses consent to treatment, that consent could be obtained from a parent.

However, in Scotland, the issue of whether a parent can consent where a competent child refuses has not been tested by the Courts. A Court could authorise treatment, under the Children (Scotland) Act, where a competent child refuses, but this is not a situation which occurs often in dental care. Apart from that, the refusal of consent from a competent child should be respected.

Dental Protection would therefore advise that it is appropriate to try to encourage the patient and consenting adult to reach a consensus.

5. Gillick **v** West Norfolk and Wisbech Area Health Authority [1986] AC 112
6. Re-R(A Minor) 1991 4 ALL ER

4.0 AUTHORITY

4.1 COMPETENT ADULTS

Clearly, in the case of an adult aged 16 years or over who is of sound mind, s/he 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.

4.2 CHILDREN

Most children eventually reach an age where they can grasp relevant facts about their body and about proposed treatment to it. They can give consent to treatment, but the degree of understanding can vary in relation to the complexity of the treatment envisaged. A few children are never, even when adulthood is reached, capable of properly understanding the information given to them and must therefore be considered incapable of giving consent.

In Scotland the Children (Scotland) Act 1995 defines who has parental responsibility and the consequent right to give consent to a child's treatment. Understanding who holds parental responsibility is not always straightforward and differences in the child's date of birth may now mean that a father may hold parental responsibility for one child but not for their older sibling.

All mothers have automatic parental responsibility. Parental responsibility rests with both parents, provided they are named on the birth certificate and regardless of whether they are married or not, for children whose births were registered from:

- 15 April 2002 in Northern Ireland
- 1 December 2003 in England and Wales
- 4 May 2006 in Scotland.

For children whose births are registered prior to these dates, the father would only have parental responsibility in the following circumstances:

- If he and the mother were married at the time of the conception, birth or sometime after; this responsibility is not lost if the mother and father later divorce;
- If he and the mother were never married, but he has a parental responsibility agreement with the mother or a parental responsibility order from the court.

Other people may gain parental responsibility by court order or by being appointed guardian upon the death of the parents. Care is required where children are looked after by a local authority. If the child lacks capacity to consent then it is essential to clarify who has parental responsibility. If the child is the subject of a care order, the Local Authority has parental responsibility which is shared with the parents. If the child is in care voluntarily, parental responsibility remains with the parents. If a Court has made a parental responsibility order in favour of the local authority, then the consent of the local authority is required.

If two people have parental responsibility for a child, one can be given access without the other being informed. For example, if a child lives with its mother, the father can obtain access without the mother being informed. There are a limited number of procedures where both individuals holding parental responsibility must give consent including vaccination and circumcision.

Difficulties can arise with determining parental consent, and in these cases caution is advised and consideration should be given to the merit of withholding treatment if doubt exists.

4.3 THE INCOMPETENT ADULT

The Adults with Incapacity (Scotland) Act 2000 is the overarching legislation in Scotland which deals with the issue of capacity to consent and is intended to safeguard the welfare and finances of adults who lack capacity to consent due to a mental disorder or inability to communicate.

Additionally, the Mental Health (Care and Treatment) (Scotland) Act 2003 is now largely in force, replacing the Mental Health (Scotland) Act 1984. Both acts provide for delivering healthcare to adults who are unable to make treatment decisions themselves.

The relevant part of the Adults with Incapacity (Scotland) Act 2000 is Part 5 which came into force in July 2002. For the purposes of the Act, an adult is considered to be an individual aged 16 and over and the Act allows other people to make decisions on behalf of such adults, subject to various safeguards. The main groups of individuals who are intended to benefit include dementia sufferers, persons with learning disabilities, acquired brain injuries or severe chronic mental illness and people with a severe sensory impairment. The law in Scotland generally presumes that adults are capable of making decisions for themselves and it is important to recognise that simply because an individual has an illness, such as dementia, this does not necessarily mean that the person cannot make decisions for him or herself.

Under the Act, a welfare attorney can be appointed by an individual, whilst that individual still has capacity, to act as their welfare attorney in the event that capacity is lost at some point in future. Additionally, following an application to Court, a guardian can be appointed with healthcare decision making powers. Where either a welfare attorney or a guardian have been appointed, any treating medical or dental practitioner must seek the consent of that welfare attorney or guardian where it is practical and reasonable to do so. Where the adult has no such proxy in place, a doctor is authorised to provide medical treatment, subject to certain safeguards and exceptions.

For the purposes of the act incapacity means incapable of:

- Acting on decisions; or
- Making decisions; or
- Communication decisions; or
- Understanding decisions; or
- Retaining the memory of decisions.

The aim of the Act is to protect those persons who lack capacity but also to support the involvement in making decisions as far as an individual is able to do so.

The act provides principals which must be followed, as follows:

1. Any action or decision taken must benefit the person;
2. Any action or decision taken should be the minimum necessary to achieve the purpose;
3. Account must be taken of the present and past wishes and the feelings of the individual concerned as far as this may be ascertained;
4. Account must be taken of the views of others with an interest in the person's welfare, such as primary carer, nearest relative, named person, attorney or guardian.

There are various bodies in Scotland involved in the regulation and supervision of those individuals who are authorised to make decisions on behalf of a person with incapacity.

4.4 ASSESSING LACK OF CAPACITY

An individual's capacity must be assessed specifically in terms of their capacity to make a particular decision at the time it needs to be made.

This means that a person may lack capacity to make a decision about one issue but not about others. Care must be taken not to judge an individual's capacity merely by reference to their age, appearance or medical condition

Supporting the person to make the decision for themselves

It is important to take all possible steps to try to help people make a decision for themselves before deciding that someone lacks capacity to make a particular decision.

In supporting someone to make the decision themselves it is important to provide all necessary relevant information. The Code of Practice specifically sets out that in relation to medical treatment the doctor must explain the purpose and effect of the course of treatment and the likely consequences of accepting or refusing treatment. The Code of Practice sets out guidance on supporting a person to make the decision themselves.

Two-stage test of capacity

Any practitioner assessing someone's capacity to make a decision for themselves for the purposes of the Act should use the two-stage test of capacity.

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does that impairment mean that the person is unable to make the decision in question at the time it needs to be made?

Assessing the ability to make the decision

A person is unable to make a decision for himself if s/he is unable:

- To understand the information relevant to the decision;
- To retain that information;
- To use or weigh that information as part of the process of making the decision; or
- To communicate his decision (whether by talking, using sign language or any other means).

The person must be able to hold the information in their mind long enough to use it to make an effective decision. However, people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide.

In any proceedings under the Act any question as to whether a person lacks capacity must be decided on the balance of probabilities.

4.5 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 Act requires people to take certain steps to help them assess whether a particular act or decision is in a person's best interests.

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 (eg, 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 (eg, 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.
- For decisions about major medical treatment, where no-one fits into any of the above categories an Independent Mental Capacity advocate (IMCA) must be consulted.

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.

4.6 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.

4.7 AUTHORITY TO TREAT

Persons who have been formally appointed as a welfare guardian or attorney under the Act can consent to treatment for the incapable adult if they have been granted this power. Additionally, in some cases, even where there is a guardian or attorney, persons identified in Part 5 of the Act, which include the medical practitioner primarily responsible for the treatment of the adult, a dental practitioner, ophthalmic optician, registered nurse and other individuals who fall within such description of persons as may be prescribed by the Scottish ministers, can sign a Section 47 certificate in order to provide authority to treat.

The Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 clarify that only persons *who have undergone a specific training course* can sign section 47 certificates.

The appropriately trained medical or dental practitioner concerned must decide if the patient is able to understand the specific treatment being suggested and make an informed decision. It should be born in mind that an individual might be able to consent to some treatment but not to others and if practitioners are in any doubt then they may wish to seek advice on the specific situation.

Where a patient isn't able to make a decision for themselves and no guardian or attorney has been appointed then an appropriately trained doctor or dentist can use Section 47 of the Act which allows them to sign a certificate which states that the person cannot make a decision and details the proposed treatment. The healthcare practitioner then retains the certificate and carries out the necessary treatment. Where an individual needs more complicated care or ongoing medical treatment then the trained doctor / dentist can use a treatment plan under the Act which sets out the detailed care which is required. In that situation, there is no need for a section 47 certificate to be signed every time treatment is needed.

Section 47 certificates can be used to authorise most medical procedures and treatment but serious and irreversible treatment would be regarded as being so serious that they may need to be approved by a court (the Court of Session). If there is disagreement, an independent clinician nominated by the Mental Welfare Commission can become involved and nominate an independent practitioner to make a decision. If disagreement remains then the attorney or guardian can ask a court to decide. An individual's family would be required to seek immediate legal advice about a court application. In the meantime, only necessary care can be provided to protect life and prevent serious deterioration of a patient's condition.

Certificates must be in the prescribed form and must specify how long the authority to treat is valid. The time period concerned is the period which the issuing practitioner considers appropriate to the particular treatment and the patient concerned. These certificates should not normally be for more than one year but can be for up to three years in certain circumstances. Three year certificates would perhaps be appropriate where a patient has a condition such as severe dementia, severe learning disability or severe neurological disorder and where the situation is unlikely to resolve and there is no possibility of recovery.

The Code of Practice to the Act also discusses the use of treatment plans for multiple healthcare interventions and contains an example treatment plan as an annex. Such treatment plans could outline any interventions which may be foreseen over a specified period of time and can be attached to the certificate of incapacity and held within the clinical records.

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 dentolegal advisers at Dental Protection.

4.8 IN FORMATION 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 the UK, the best known interpretation of the law on the subject was, until recently, found in the case of *Sidaway*[7]. In this case, five Law Lords had to decide whether or not Mrs Sidaway had the prognosis and the sequelae of a difficult operation on her back properly explained to her prior to the operation. She had suffered permanent nerve damage as a result of the operation.

However, a recent case considered by the UK Supreme Court, Montgomery v Lanarkshire Health Board[8], has updated the law in relation to the information that should be provided to patients when discussing the risks of proposed treatment and obtaining consent. Although this case has changed the law, it has simply brought the law into line with the General Dental Council standards[9] that were already applicable.

In general terms, the attitude of the law to a doctor or dentist's duty is measured in courts in England and Wales by the application of what is known as "The Bolam Test".

This is a standard that arose from a speech given by McNair J in Bolam v Friern Barnet Hospital Management Committee[10], which was a major landmark in defining the duty of care that a doctor owed to a patient. McNair J stated:

"The test (whether there has been negligence) is the standard of the ordinary skilled man exercising and professing to have that special skill."

The best summary of this case came from Lord Diplock who felt that the "Bolam Test" was:

"Applicable to every aspect of the duty of care owed by the doctor to his patient, in the exercise of his healing functions, as respects that patient."

In Scotland the appropriate legal test derives from the case of Hunter *v* Hanley 1955 SC 200.

The Hunter v Hanley test determines whether the doctor has been guilty of such a failure as no doctor of ordinary skill would be guilty of if acting with ordinary care. In other words, a mistake made the doctor must be a mistake which no competent doctor in that field would have made. For dentists, nurses and other medical professionals simply substitute the word "dentist" or whatever for "doctor".

This is the **Hunter v Hanley** test and it is usually set down as a threefold test:

1. There must be a usual and normal practice (ie, by the doctor);

2. The doctor has not adopted that practice; and

3. The course adopted is one which no professional man (ie, doctor) of ordinary skill in that field would have taken if acting with ordinary care.

The case of *Sidaway* showed that the degree of probability of a risk arising, and the seriousness of possible injury are two important facts that a patient needs to know before being able to consent to treatment. Not only does a dentist have a duty to explain relevant facts to the patient, but the language used should assist the patient to understand, and any additional points raised by the patient should also be properly addressed.

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 patient.[11] 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.

7. Sidaway v Board of Governors of the Bethlehem Royal Hospital [1985] 1 ALL ER 643 HL
8. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104
9. Standards for the Dental Team, General Dental Council, 20 September 2013
10. Bolam v Friern Barnet Hospital Management Committee [1957] 1WLR 582
11. Blackburn C.W., Bramley P. Lingual nerve damage associated with removal of third molars, Br. Dent J. (1989) 167: 103-107

The concept in England and Wales has therefore, until the case of Montgomery, been that of the prudent dentist. What would a prudent dentist explain to a patient? The answer was found in *Bolam* was "the information which a dentist in that situation would normally be expected to explain to a patient who needs that information".

This position was re-affirmed in Scotland in the case of Moyes v Lothian Health Board.[12] Lord Caplan said:

"In my view the Sidaway case in no way alters the pre-existing view of the law that the appropriate tests to apply in medical negligence cases are to be found in Hunter v Hanley and Bolam."

However, The Montgomery case has changed this and the Bolam and Hunter v Hanley tests no longer apply to the provision of information about risks of proposed treatment. Montgomery has overturned the approach in Scotland taken in Moyes v Lothian Health Board (which affirmed Sidaway).

The clinical aspects of the Montgomery case occurred in Lanarkshire in 1999 when Mrs Montgomery was pregnant with her first child. As a Type 1 insulin dependent diabetic expectant mother, she carried a higher risk of carrying a larger baby. This brings a risk of shoulder dystocia during normal delivery, the risk being in the region of 9-10% in diabetic mothers.

Mrs Montgomery raised concerns about normal delivery but her obstetrician did not warn her of the risks of shoulder dystocia, nor of any other risks that normal delivery carried in her situation. She was not warned of the possible further consequences if shoulder dystocia occurred. The obstetrician's rationale was that although there was a 9-10% risk of shoulder dystocia (and it was accepted that this was a high risk), the risk of a grave problem resulting from shoulder dystocia was very low.

There was difficulty in delivering the baby as a result of shoulder dystocia and during the 12 minutes it took to free him he was starved of oxygen. The baby was born with cerebral palsy and suffered the loss of the use of his arm – a further complication of a brachial plexus injury sustained during the birth. Mrs Montgomery raised an action alleging clinical negligence in the Court of Session in Edinburgh and argued that had she known of the risk of shoulder dystocia, she would have asked for a Caesarean section.

The case was initially decided in favour of the defenders and an appeal to the Inner House of the Court of Session also failed. Mrs Montgomery therefore appealed the UK Supreme Court which allowed the appeal and Mrs Montgomery was awarded £5.25 million in damages. In their analysis of the facts of the case, the Supreme Court considered the pre-existing case law in relation to disclosure of risks and the standard of care.

Until Montgomery, the test to be applied when disclosing risks was that of the prudent clinician and the tests laid out in Bolam and Hunter v Hanley. That has now been overturned by the Montgomery case. The Bolam and Hunter v Hanley tests have clearly been considered by the Court to have been rather too paternalistic, from a "doctor (dentist) knows best" perspective.

4.9 MATERIAL RISKS

In an Australian case (Rogers v. Whitaker)[13], 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" ie, 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?

What matters more 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.

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.

12. 1990 SLT 444
13. Roger v Whitaker (1992) 109 ALR 625-631 [1993] 4 med LR 79-82 (High Court of Australia)

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 GDC's *Standards for the Dental Team*[14] also requires that a patient returning for treatment should be given a written treatment plan:

"You must give patients a written treatment plan, or plans, before their treatment starts and you should retain a copy in their notes. You should also ask patients to sign the treatment plan."

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.

The Montgomery case now essentially brings UK law into line with the Rogers *v* Whitaker decision.

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.

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

4.10 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 (10).

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 and Montgomery judgments (see above) are helpful to us in our understanding of the patient's perspective.

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.

14. *Standards for the Dental Team*, General Dental Council, 20 September 2013

4.11 "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"[15] 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.

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 dentolegal 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.

15. Kennedy I, Grubb A; *Medical Law*; Butterworths, London 2000

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.

4.12 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 care 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.

5.0 ASPECTS OF CONSENT

The General Dental Council is involved in various matters of consent, as ethical issues which reflect upon the professional conduct of a dentist. The General Dental Council identifies the main ethical principles of getting consent as:

- Informed consent
- Voluntary decision making
- Ability.

The Guidance puts flesh on the bones of these basic principles and all dental registrants are advised to familiarise themselves with the Guidance.[16]

5.1 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.

5.2 GENERAL ANAESTHESIA AND SEDATION

The General Dental Council (GDC) 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.

The General Dental Council requires that a valid consent to treatment under general anaesthetic or sedation must be obtained, and confirmed **in** writing[17] by the patient (or parent) prior to carrying out the treatment. The dentist must himself (or herself) have explained to the patient the treatment proposed, the risks involved in the treatment, and any alternative treatments. All the procedures involved in the anaesthesia/sedation, and in the dental treatment itself, must be explained to the patient. The Council makes it clear that the onus is on the **dentist**[16] to ensure that all necessary information and explanations have been given to the patient or parent / guardian, either by the dentist or by the anaesthetist. It is not acceptable for these explanations to be given by a member of the practice staff.

16. *Standards for the Dental Team*, General Dental Council, 20 September 2013

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.

5.3 PRIVATE OR NHS?

The General Dental Council considers that it is the responsibility of the dentist to explain the nature of the treatment plan clearly to the patient, ie, whether the treatment is being provided under the NHS, or privately.

Patients must never be misled into accepting private treatment. The dentist is must encouraged to avoid misunderstandings by giving the patient a written treatment plan and estimate. Dentists should ask patients to sign the treatment plan and retain a copy in the notes.

In this context, NHS practitioners are reminded that they are obliged, under paragraph 4 of Part II of the Terms of Service, to provide the patient with a plan for treatment on a from supplied by the Health Board at the time of the first examination and in certain other circumstances, including where all or part of the treatment which is necessary to secure and maintain oral health is to be provided privately. The patient should sign (and ideally, should also date) the completed top copy of the form, the bottom (self-carbonating) copy of the form being retained safely in the patient's notes.

There can be no better defence against a subsequent allegation that the patient was not aware that the treatment was being provided on a private basis – an allegation which could well be the subject of a HB investigation and/or a complaint to the General Dental Council.

5.4 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.

5.5 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.

6.0 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

7.0 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 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 General Dental Council.

7. Keep good and careful records of all matters concerning the question of consent.

NOTES

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