King's Fund

Consent in Dental Care

Jenny King
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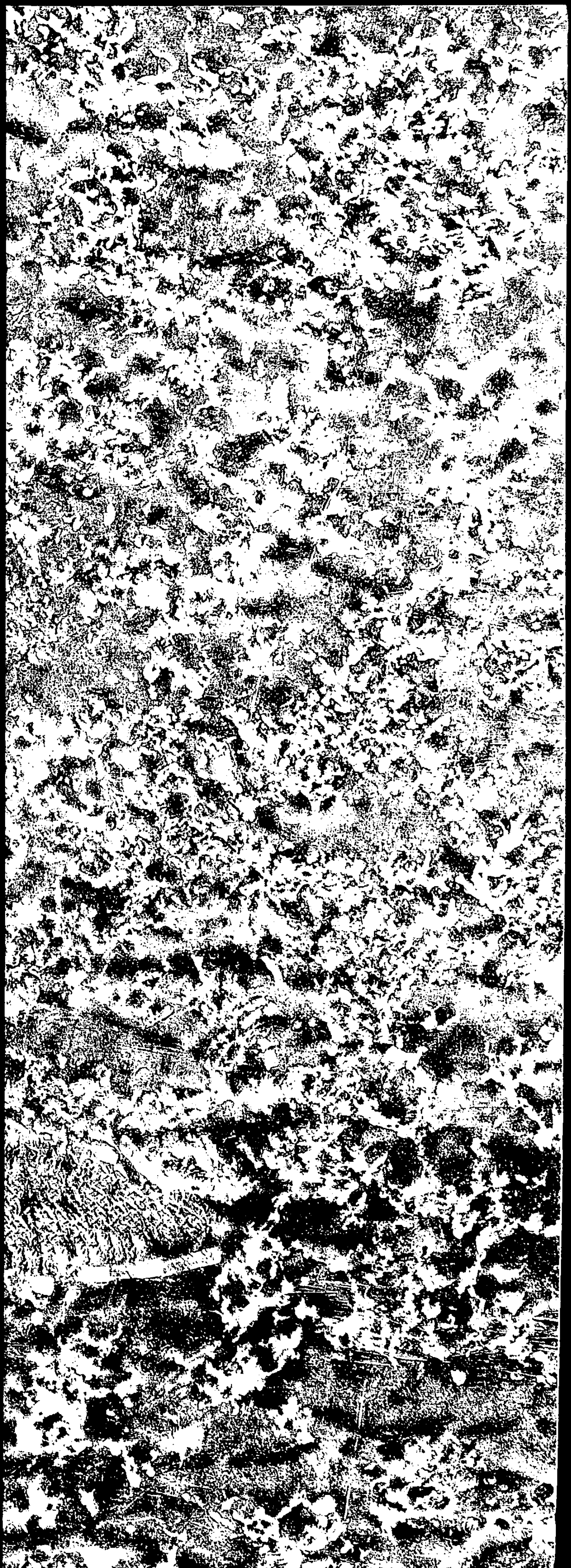

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Contents

The child is taught that he is free, a democrat, with a free will and a free mind, lives in a free country, makes his own decisions. At the same time he is a prisoner of the assumptions and dogmas of his time, which he does not question, because he has never been told they exist.

Doris Lessing. *The Golden Notebook.* Flamingo, 1993.

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1. The study

In today's multicultural society there is renewed concern to respect common moral values. Nowhere is this more important than in health care. In dentistry the General Dental Council has recently placed new emphasis on appropriate attitudes and good professional conduct towards patients in maintaining high standards of care, including the importance of patient consent, stating that:

> *A dentist must explain to the patient the treatment proposed, the risks involved and ensure that appropriate consent is obtained.*[1]

The increased awareness of patient rights, and the threat of litigation if treatment is not explained, make it essential for the professional obligation to obtain informed consent to be taken very seriously.

Informed consent is much more than a formality or a signature on a form. Rather it concerns the intricate and detailed exchange between dentists and patients that must first take place. However, although the principles of informed consent are reasonably well established in dentistry in the UK,[2] the dynamics of the exchange between dentists and patients in practice are less well understood. There is a need to know more about the difficulties that are encountered and what constitutes good practice.

Informed consent is an ethical and legal obligation of clinical practice that demands good communication skills. Its implementation at the chairside requires an awareness of the patients need to know and have a choice about what is happening to them. This presents challenges to dentists, not only when treating competent adult patients – especially in overcoming cultural and language barriers[3] – but also in appreciating the particular needs of vulnerable adults,[4] and children.[5]

In this country the law as it stands at present states that no adult may act as proxy for another adult, and clinicians must act in the best interests of patients they judge to be incompetent,[6] when they have impaired understanding, reasoning, recall or acceptance.[7] Legal consent for children must be given by a parent or guardian but the child has a right to be consulted. If judged competent and mature enough young people below the age of 16 may in some circumstances give their own consent.[8]

Most of the research into the social aspects of the dentist–patient relationships has taken a clinical or behavioural science perspective, but this research brings a new perspective, that of the ethical legal and professional obligations that clinicians have towards their patients. Ozar and Sokol[9] in their book *Dental Ethics at Chairside* consider different models of relationships in dental care. They describe a dentist-led model, a patient-led model, and a commercial model. However, they reject these models in favour of an interactive model where both patient and dentist are actively involved in the consenting process in greater partnership.

1.1 The research objectives

The overall aim of the project was to explore the process of obtaining informed consent in dentistry in order to develop a model for good practice. The specific aims were to find out the range of clinical practice, and discover any difficulties that dentists and patients encounter, including categories of vulnerable patients for whom there are particular ethical and legal issues in obtaining consent. At the outset nine stages in obtaining informed consent were proposed: the initial introduction, explaining the dental problem, outlining treatment options, communicating risks and benefits, estimating time and cost, inviting questions reaching mutual understanding, confirming choices, and indicating consent. The working hypothesis is that these stages are all addressed in the dental consultation.

1.2 Methodology

Consent was investigated from four different perspectives: observation in the dental clinic, a postal questionnaire to dental practitioners, an interview with clinicians, and an interview with patients. The study focused on four defined groups of patients based on their legal ability to give consent, adults, adults without a shared language, vulnerable adults and children under the age of 16.

Most of the study was conducted in a dental teaching hospital in east London that serves a multicultural community in a deprived inner city area. The postal questionnaire was sent to a national sample of dentists on the Dental Register. The observations, interviews, and questionnaires related to the nine component stages of informed consent. Data collection and analysis was carried out using both quantitative and qualitative methods and appropriate computer packages, SPSS and QSR.NUDIST4.

1. The observation of clinical settings

The study started in the dental clinic. The aim was to observe the context in which consent is negotiated between patients and dentists. Observations were made in three dental clinics, an Adult Clinic, a Special Needs Clinic and a Children's Clinic. Each of the identified groups of patients was observed on three different occasions. The periods of observation lasted for about an hour-and-a-half. The researcher was a passive observer at the clinic. Only brief notes were made at the time but immediately afterwards a description of the observations and a reflection was written up in detailed field notes.

2. The postal questionnaire to dentists

A postal questionnaire was sent to dentists. The overall aim was to investigate dentists' experience of obtaining consent in practice. Questionnaires were sent to a random sample of 450 dentists; 264 (59 per cent) responded. However some responses were not useable because dentists were not in clinical practice. Valid responses were received from 234 dentists.

3. The interview with clinicians

The third part of the study was an in-depth interview with dental clinicians. The aim was to explore the clinicians perspective of consent, the component stages, their experience with different patient groups and their views about any practical value of informed consent. The researcher interviewed twenty dentists who were actively engaged in clinical practice. Although all of the dentists recruited spent some time working in a dental teaching hospital, they also had experience of working in dental practice. Each interview lasted for about 45 minutes. The interviews were recorded and transcripts were made of the audiotapes.

4. The interview with people receiving dental care

The fourth and final part of the study considered consent from the perspective of those receiving dental care. The aim was to investigate peoples' perceptions of how they had been informed and how the dentist had obtained their consent to dental treatment. Sixty people were interviewed by the researcher using a semi-structured interview schedule. Each interview lasted for about 20 minutes. The dentist recruited patients in the clinic as they completed their dental treatment. The only condition was that they had received some dental care; there was no attempt to control the type of care received. There were 15 people in each patient group. Where appropriate interpreters, carers and parents took part in the interview.

In this way evidence about how consent is obtained was gathered from a number of different sources. Together these four perspectives build up a clearer and more complete picture of what happens at the chairside. Although this study has used some quantitative methods, much of it depends on qualitative methodology in the clinical observations and the analysis of the transcribed tapes and the categorisation of dentists' comments. This methodology has not been widely used in dentistry. However the value of such research in health care generally is now much more widely acknowledged. The findings are validated by considering the consistency of the findings when viewed from a number of different perspectives.[10, 11]

This summary report of an investigation of the process of informed consent in dental care first describes the stages in the informed consent process and the practical realities of applying these stages during the dental consultation. Next the challenges of obtaining consent for vulnerable groups of patients are considered. In this way the more normal situation is explored first, and has deliberately been separated out from those situations that may more obviously present difficulties. Finally the value of informed consent for patients, dentists and the relationships between them is considered. This is followed by a discussion and recommendations of ways in which consent might be made more explicit in dentistry in the future. All of the data was collected anonymously and where names have been used in the text they have been changed.

2. Stages in the process of obtaining informed consent

In a contemporary account of medical ethics that is now widely accepted Beauchamp and Childress[12] add to the traditional moral principles of doing good and not doing harm, the moral obligation of respect for autonomy. The practical outcome of respecting autonomy is that treatment does not proceed without first obtaining a person's explicit and informed consent. In health care informed consent has become a shorthand expression for a process within the clinical consultation which establishes a relationship between those who provide and those who receive care, and which is based on information, understanding, and freely given consent.[13] Dentists providing care for patients encounter the ethical and legal issues of consent everyday as the consenting process is integrated into the sequence of history taking, examination, diagnosis and treatment planning. Obtaining informed consent, and the partnership that it creates, is an integral part of all good clinical care. One clinician who took part in this study went so far as to say that for her it was the most important aspect of care and the most rewarding.

In our work in teaching applied ethics and law to dental students, we have developed a model that describes the process of informed consent in practical terms. The model is derived from acknowledged theoretical principles, that is that people should know about the nature of their problem, the treatment and any options and risks, and that consent should be based on understanding and non-coercion.[2] These principles have been translated into a sequence of events in the dental consultation. They include introductions, explaining the dental problem, outlining treatment options, communicating risks and benefits, estimating time and cost, inviting questions, reaching mutual understanding, confirming choices, and indicating consent. Each stage is a fundamental building block in the overall process of obtaining informed consent which starts with giving appropriate information and leads up to obtaining a person's consent to treatment in what one clinician called a, 'rolling process'. Considered on their own these stages are not new to dentistry. What is new is identifying them as collectively making up the consenting process.

Box 1: Stages in the process of obtaining informed consent

0. Making introductions
0. Explaining the dental problem
0. Outlining treatment and options
0. Communicating risks and benefits
0. Estimating time and cost
0. Inviting questions
0. Reaching mutual understanding
0. Confirming choices and agreement
0. Indicating consent

It is the purpose of this section to describe how clinicians interpreted the process of obtaining consent in their own clinical practice and to see how this conforms to the stages that have been proposed. In the in-depth interview, clinicians were asked to outline the procedures they would normally use when obtaining consent from patients. Their replies are used to explore the range of clinical practice in relation to the identified stages. The dentists' views – both for and against – are illustrated with quotes obtained in the interviews.

2.1 Stage 1: The initial introduction

The process of informed consent starts as dentist and patient first meet each other. It was suggested that the best setting for obtaining consent is for dentists and patients to talk away from the clinic with both seated at the same level. Another possibility is for the dentist to meet the patient in the waiting area where initial introductions are made and names can be exchanged. A cramped dental surgery with the patient lying in a dental chair and the dentist seated behind them is not the best way to begin a conversation.

> *I think you have to establish a rapport very quickly, so what I like to do, if the situation is ideal, is to greet my patient in a non-dental setting, first of all without my white coat. I introduce myself, say who I am and what I am going to do. I suppose that is the very early part of the consent.*

At the outset the need to obtain consent is explained.

> *We would begin the process by saying we have to go through what is happening in order to obtain your permission to go ahead.*

The scene is then set for obtaining consent for dental treatment by developing an initial rapport and explaining the dentists express intention of providing information and then seeking the patient's consent.

2.2 Stage 2: Explaining dental problems

Fundamental to planning any dental treatment is an understanding of the problem that a person presents with.

> *Really consent starts with question and answer, with the patient being encouraged to discuss their symptoms.*

Sometimes a problem may be obvious, for example a broken tooth. On other occasions the dentist may identify a problem which the patient has been unaware of, such as symptom-free periodontal disease. In this process of exchange the patient and the clinician together build up a picture of the problem. Even at this stage as the dentist listens they will be able to assess how much the patient already knows. Dentists described how they added their professional explanation of the problem to the patient's own understanding. A balance has to be struck between giving people enough information but not overloading them with too much clinical detail. A diagnosis may not always be conveyed at one visit. An example was given of oral cancer and how giving the information was staged as tests confirmed the clinical diagnosis. In this way a person has time between visits to digest the information. Providing appropriate information must be carefully worded and carefully timed but at the outset people need the dentist to give them a straightforward and simple account of what is wrong.

2.3 Stage 3: Outlining treatment and the possible options

If a person is to consent freely to any proposed treatment they must know the reason for the treatment, what it entails and any possible alternatives. At the very least the options will be treatment or no treatment. An explanation about each possible treatment and likely outcome is important in order for a person to be able to choose their best course of action. One dentist who worked in the Casualty Clinic explained how people might not always be aware that they have any choice, and assume that extraction is the most likely outcome. However other clinicians thought that the situation was changing and that patients now are coming to realise that they do have options. Clinicians may sometimes wrongly assume that patients know about alternative treatments.

> *The difficulty is that sometimes as a clinician you forget that they don't know the other options. You assume they know them and they don't.*

Dentistry frequently presents a number of different possibilities, each of which may be equally acceptable clinically.

> *Nearly all my procedures are elective so the patient has a choice in the type of treatment they are going to have. I can get almost the same result restoring the mouth in a number of different ways and it's important that patients make the decision based on the information I give them.*

It is important for the dentist and the patient together to work out the aims of treatment. One clinician gave the example of a patient who has found it difficult to tolerate full dentures. The question should be what does that person want the outcome to be, there is no point in going ahead with another set of dentures unless it is what the person really wants. Informing patients about the available options is the foundation for interactive decision-making. Without this knowledge a person cannot make an informed choice.

2.4 Stage 4: Weighing up risks and benefits

No interventive procedure is without some measure of risk, however most routine dentistry carries very little risk. In making decisions a person must have some information about the complications, side effects and significant risks that are associated with any proposed treatment. A distinction was made between common complications that are transient, such as pain or bleeding following a tooth extraction, and permanent damage, such as numbness following the surgical extraction of a wisdom tooth. For a number of procedures the associated risks have been systematically investigated. It is therefore possible to explain to patients the likelihood of a known risk occurring, which is based on scientific evidence. One example given was the likelihood of failure in root canal therapy.

> *Certainly I would try and give them some estimate of risk. For example trying to do a root treatment that had failed you might say to them the chances of success when one first does a root filling are 90 per cent, but that usually if you redo a root filling your chances are getting down to the 50 per cent level.*

If clinical evidence shows that there may be risks it is important to warn the patient of this, and to document that the risk has been explained in case any dispute should arise. An oral surgeon gave the example of surgery for the extraction of a wisdom tooth where there was a definite risk that the jaw could fracture. This was explained to the patient beforehand and documented. The jaw did break but she had no case in law because the risks had been explained and her written consent had been given. Clinicians mentioned that recent court cases about nerve damage following wisdom tooth extraction have heightened awareness that failure to warn about significant risks may be considered negligent.

Any consideration of risks must be balanced with the benefits of treatment. The difficulty that dentists have in explaining risk is reduced if the expected benefits are presented at the same time so that risks are put into perspective. One example that clinicians gave was of weighing up the risks and benefits of the very small but extremely serious risk, even with specialist hospital facilities, of morbidity or mortality associated with general anaesthesia for the extraction of primary teeth for a child. The risk must be balanced against the benefits of relieving pain and removing carious teeth in one operation, rather than a long course of treatment under local anaesthesia for a very young child. There may be occasions when dentists and patients agree to take a chance, such as agreeing to repeat a failed root canal treatment, knowing that it may fail again. Here the risk of failure must be weighed up against the benefits of saving a tooth. Communicating risk and benefit in an honest but non-threatening way is not easy. On the one hand dentists do not want to cause unnecessary worry. On the other hand, however, it is only fair that patients should be aware of the risks as well as the benefits of their treatment. This is a sensitive area but it is essential if patients are to be fully informed.

2.5 Stage 5: Estimating the outlay of time and money

The likely outlay that a patient must make for any proposed treatment is expressed in terms of both time and money. People need to plan their time. It is therefore important that they are informed about the time that dental treatment will take. This includes the time that any appointment can be expected to last, the number of appointments that will be required, and when treatment can expect to be completed. People need to know any costs of treatment, whether this is a National Health Service contribution, an arrangement with independent insurers or a private financial transaction between the dentist and patient. If a person is exempt from NHS charges because they receive state benefits such as income support, this should also be clarified at the outset. Clinicians explained that discussion of cost is becoming more important since the introduction of significant increases in patient charges for NHS dental treatment, and costs of private treatment. An example given was in deciding about whether a painful tooth should be extracted or root filled. An extraction has the advantage of being quick and cheap but the tooth is lost, whereas a root treatment may take several visits and cost much more money but the tooth is saved. Knowing how much time and how much money a particular treatment is likely to entail is more information that a person needs in order to come to an informed decision about different treatment options.

2.6 Stage 6: Inviting questions

Providing the opportunity for patients to ask questions is an important part of preparing the way for consent since it is a chance for a patient to express to the dentist any unresolved concerns or anxieties they may have, or to ask about any aspects of the treatment that they have not understood. Even a seemingly simple question may draw attention to something that had not previously been considered. A dentist who specifically asks patients if they have any questions helps to create a climate where a patient can feel confident that their concerns are taken seriously and addressed. If questions are dealt with in a cursory way a patient will feel less likely to ask again. For some clinicians this is a passive process where the possibility of asking questions is not excluded but it is not actively considered.

> *I don't think this is ever a conscious process. But I hope that I would always say to them is there anything else that you would like to know, or anything you are anxious or worried about, or do you have concerns about any of this?*

Others make a definite point of inviting questions.

> *If there is anything that is not explained or they don't understand I encourage them to come back and speak to me, write to me, call me any time I am at the practice. I will always speak to people and they know that I will.*

However past attitudes have not encouraged patients to ask questions. The dental environment may at times be very intimidating so that people do not even frame questions. Clinicians remarked how they were sometimes surprised that even when they were offered a chance patients did not ask any questions. One dentist described how she often encountered a 'parent and child relationship' between dentist and patient where there is no expectation that questions would dare to be asked. She suggested:

> *... perhaps if you can help them by saying you are listening and try to encourage them to come forward with more questions. But I think it's these barriers that we need to break down generally before we get patients to be more questioning about treatment.*

Sometimes clinicians cannot answer a question and it may be important to admit this rather than invent some simplistic or misleading answer. Clinicians thought that far from loosing trust in a dentist a patient is likely to respect a clinician for admitting that they do not always know all of the answers. When the clinician invites questions from the patient this sets up a dialogue. It is an opening up of the consultation and an important invitation to patients to become more involved. Without this dialogue the patient's perspective remains unknown to the dentist.

2.7 Stage 7: Reaching a mutual understanding

Good communication is clearly important if mutual understanding is to be reached between dentists and patients. Each must both talk and listen to the other. Feedback from patients helps to make sure that clinicians and patients have understood each other.

> *I always say have you understood. I ask them to go through it again and explain what they have understood... I used to do enormous long monologues but now I stop at intervals and try to get feedback.*

This way people can come to a greater awareness. This is important if the hoped for changes in behaviour, for example in oral hygiene, are to be achieved.

> *I think periodontal treatment is very much about communication, patients will only get better if they will treat themselves properly. We try to get them to be more aware, so it's all about talking.*

However patients may feel anxious and find it difficult to take in and understand all that has been said in a consultation. One dentist explained how the presence of another person, most often the dental nurse, may help them to be able to reflect later with her about what has been said. If treatment is particularly complex a relative or friend may be invited to a consultation so that a person can go home and think about it afterwards and talk with someone else who was there about what was said. People need space to think about the information that they have been given, especially if it is complex. Reflecting between appointments and talking to others before coming to any decisions will help in developing a deeper understanding. In this way understanding is built up over time. Understanding cannot simply be assumed. Just because information about treatment has been given it does not mean that it has all been taken in or fully understood. There needs to be some mechanism within the consultation for ensuring that a level of mutual understanding between the clinician and the patient has been reached. Finding appropriate ways of checking understanding by summarising and seeking feedback helps to reassure dentists and patients that they have understood each other before any treatment proposals are agreed to.

2.8 Stage 8: Confirming choices and reaching agreement

Clinicians describe a time in the consultation when they arrive at a natural point when a state of agreement has been reached.

> *There is a state of agreement reached between you. You have come to the point of saying right, OK, are you happy with that. Then basically you proceed.*

However clinicians acknowledged that although they explain treatment to patients it is very often the dentist who decides about the treatment.

> *I confirm the treatment by telling the patient what is available and what I feel is the most appropriate course, giving them the opportunity to agree. If they disagree I may have to attempt to convince them if I believe this is in their best interests.*

They recognised that dentists could sometimes be quite persuasive in making decisions about treatment. This means that patients are often told rather than asked.

> *I think it's very easy for the dentist or doctor to say things in terms of what they want to do, in a way that almost gives the patient no choice whatsoever.*

Other clinicians would want to be more open to debate rather than to impose any particular treatment and would only proceed when agreement was reached following a discussion about choices.

> *My treatment planning is always on the basis of an agreement between myself and the patient rather than my diagnosis being arrived at and then me imposing it on a patient. I feel that I would debate it with them... I might present my own view on what I think is the best course, but I would try to do it in a way that would allow them to express their own views, not to feel that I was directing them in one particular way... maybe to guide them but not to say I think the best thing to do here is this, and imply that they have got to agree with me.*

However dentists thought that some patients may not want to take decisions for themselves and would rather leave the choice up to the dentist.

> *Patients do often say, I am in your hands, or you are the boss, what do you recommend? Recommendation is one thing but to go ahead and do what you feel like doing is not really a safe area to be working in, unless this is what the patient really does want you to do.*

Dentists must guard against the possibility of in any way forcing treatment on a patient that they do not want. Overriding a patient's decision is an unacceptable abuse:

> *If you are going to carry out treatment against the wishes of your patient you are being a bully. We are an intimidating profession without having to bully our patients.*

Agreement may be assumed because the patient does not refuse treatment or a patient may indicate their agreement with a nod of their head. But a more interactive approach is to ask specifically if the patient now feels able to make their decision about treatment based on the information that they have been given and the understanding that they have now reached. Then the dentist and patient together have come to an active agreement to proceed.

2.9 Stage 9: Indicating consent

The most common form of consent in dentistry remains consent implied by the patient's presence. Consent may be neither specifically asked for by the dentist nor specifically given by the patient.

> *I think there is a whole generation of dentists out there who believe that the mere fact that a patient walks through the door is consent.*

But clinicians were critical of the assumptions about consent that dentists have made, and that this is no longer acceptable.

> *There isn't this sort of blanket, I am here therefore you may do what you like. That may have been all right for the previous generation, it's possibly what some of my generation do, it's not acceptable now, and it's not acceptable in the future.*

Consent may be more explicitly obtained by a definite question put to the patient about whether or not they consent to the treatment that has been discussed accompanied by a definite affirmation by the patient that they do. The detail of this consent is recorded in the notes as a matter of good practice and is important should a dispute ever arise. For instance in the case of a complaint about residual numbness following wisdom tooth extraction a clinician commented:

> *It's a good job that the house officer had written in the notes that he had warned the patient.*

Now many dentists are beginning to move towards a written consent form which contains the detail of what has been agreed to and is signed by both the clinician and the patient. However some clinicians who were interviewed did express mixed feelings about written consent:

> *I am a bit ambivalent about it. I think it could be over the top a bit. Also it's a matter of how much detail you put on a form that people will understand what is written.*
>
> *Consent forms are only of interest to lawyers, not very much to doctors and patients.*

The main concerns expressed about consent forms were more about how they are used rather than the idea of written consent itself. Poor timing may break into the natural flow of a consultation. A cursory handling of the form may defeat the object of providing information and choice. Then an over technical approach to describing potential risks may cause undue anxiety. A legalistic approach may change the nature of clinical relationships.

Despite these misgivings clinicians saw major benefits from obtaining a patient's consent in writing, thereby reducing the possibility of misunderstandings:

> *If the patient has signed a specific consent form it does remove a lot of ambiguity and misunderstanding that can occur between patients and clinicians.*

Written consent is a permanent record, giving a clearer picture of what is involved in the treatment.

> *The patient I think has a clear understanding of what is proposed. Not only have you explained what you are going to do, but when they see it in print it does gel everything together. I am sure it concentrates the mind, gives them a clear understanding. It's part of the package.*

Once information has been exchanged, a reasonable level of understanding has been reached, and the treatment of choice has been agreed, the dentist and patient can then signify in writing that informed consent has been obtained.

> *Consent is getting involved, it's a partnership. That partnership is cemented when dentist and patient can positively indicate the agreement that they have come to, so that each can say with some confidence that treatment has been explained, understood and freely consented to.*

The process of informed consent has been presented here as having nine stages. Together they represent what good ethical and legal principles in obtaining consent might look like in practice. Each individual stage was recognised by dentists and reflected in their comments. To a greater or lesser extent the stages were described as part of the consent process that they used in practice. The evidence suggests that these stages are sometimes included in the dental consultation but that this is not always so. Offering patents choices, inviting questions, making sure that a person has understood before obtaining consent was evidence of good practice. But dentists were also conscious that they might not always explain alternatives, that inviting questions is not always a deliberate part of the consultation, that understanding is not always checked. Clinicians may simply tell a patient what they intend to do rather than making decisions together. A person's agreement may not be actively sought and consent is not always made explicit. So there is evidence on both sides. In the reality of the dental consultation the clinicians own account described a fragmented approach to consent.

It does not necessarily follow that because dentists recognise and describe in some detail the individual stages making up consent that there is a complete understanding of the process as a whole. Furthermore the model is an oversimplification of the practical reality. In the next section consent will be considered in more detail with evidence from three other sources: clinical observations, questionnaires to dentists in practice, and patients receiving dental care.

3. The practical realities of obtaining informed consent

A model consisting of nine different stages in the process of obtaining informed consent has been described in the previous section. This next section considers what happens in the practical reality of the dental clinic. The observations in the clinic, the replies of dental practitioners and the responses of people receiving dental care describe the day to day transactions between dentists and patients and their perceptions of how consent to treatment is obtained.

3.1 Observations of dentist–patient interactions in the clinic

Observations in the clinic of dentist–patient interactions revealed that people were often well aware of their dental problem. It was noticeable how often radiographs were used to explain the situation further, people being invited to look at the pictures of their teeth or jaws on a viewing screen as a visual aid to explain the problem.

Alternative ways of managing the condition were sometimes discussed, for example a patient who had a problem with his wisdom teeth was told about the possible treatment options. However this was not always the case and on many occasions the dentist explained the problem and then told the patient what was going to be done rather than mentioning any possible alternatives. On the other hand patients were not forced to accept the treatment. In one case the patient was told that the tooth in question was not saveable and was offered an extraction that day, but he preferred to go away and consider what to do and perhaps get another opinion before deciding whether or not to have it taken out.

Potential risks or complications of the proposed treatment were sometimes mentioned. For example an explanation that a tooth may need to be extracted should root treatment fail, and an explanation of the risks of X-rays during pregnancy. However a discussion of risks was not a routine feature of the consultations that were observed.

Patients often appeared quite passive in the consultation and accepted the judgement of the clinician. Most often a decision about treatment emerged based on the experience of the dentist, rather than on the patient's express choice or a negotiated agreement.

Failure to discuss treatment with patients before they agree to it may result in some confusion later. One patient described how he felt after he had been persuaded to have a front tooth removed but in retrospect he returned to the clinic to question whether the tooth might have been saved.

The observations in the clinic did not show evidence of any systematic procedure for consent that was routinely used. But clinicians did follow other procedures in the consultation, most obviously a set of questions about general health. Taking a medical history was carried out routinely in every consultation.

There were no written consent forms on the clinic, and no mention of consent as such. The most that was observed was the dentist asking: 'Are you happy with that?', and the patient then nodding their agreement. Consent often remained unspoken by the patient and assumed by the dentist since the patient had requested care and come willingly into the clinic.

3.2 The perspective of dentists providing care

The replies received from 234 dental practitioners summarise consenting practice from the perspectives of dentists providing treatment. Dentists estimate that they spend on average seven minutes explaining treatment and obtaining consent, although this varied considerably between one minute and forty-five minutes. Salaried dentists and those working solely in private practice estimated that they spent on average eleven minutes obtaining consent, whilst dentists working in the NHS spent six minutes. Unlike in medicine, in dentistry it is most likely to be the dentist who will be carrying out the treatment who explains the treatment to the patient.

One particular area of confusion for dental practitioners was the status of the NHS Claims form (FP17). This was mistakenly regarded as a consent form by 63 per cent of respondents and a further 13 per cent were unsure whether or not it was a consent form. Only 24 per cent of dentists responded that this was not a consent form. This form was most often administered by clerical or nursing staff. There was also limited use of the Treatment Planning form, a copy of which should be given to patients. Only 24 per cent of dentists used it routinely and 30 per cent never used it although its use is required by NHS regulations.[14]

Box 2: Summary of replies from dental practitioners about obtaining patient consent (N=234)

- *Time spent*

On average dentists estimated that they spent seven minutes explaining treatment and obtaining consent, ranging from one to forty-five minutes. General practitioners spent six minutes whilst salaried and private dentists spent eleven minutes.

- *person explaining treatment and obtaining consent*

The same dentist who would be providing the treatment most often obtained consent and for 80% this was always the situation.

- *NHS forms*

63% regarded the NHS Claims form as a consent form and a further 13% were unsure. This form was most often administered by clerical staff, 94%.

The NHS Treatment Planning form was used routinely by only 24% of dentists, 30% never used it.

When the different stages in the consenting process were considered, dentists replied that they would routinely include explanations about the patient's problem (82 per cent) and treatment options (78 per cent). They were also likely to estimate costs (60 per cent) and confirm agreement (60 per cent). However fewer than half of the dentists would routinely explain benefits (48 per cent), invite questions (48 per cent), explain risks (46 per cent), check understanding (44 per cent) or explain the time that treatment would take (36 per cent). Fewer than a quarter of dentists (23 per cent) said that they would routinely obtain written consent for treatment.

Box 3: The proportion of dentists who said that they routinely included different stages of informed consent (N=234)

- explaining the problem: 82%
- outlining options: 78%
- estimating costs: 60%
- confirming agreement: 60%
- explaining benefits: 48%
- inviting questions: 48%
- explaining risks: 46%
- checking understanding: 44%
- explaining time: 36%
- obtaining written consent: 23%

3.3 The perspective of people receiving care

The views of people receiving dental care are considered in 60 interviews with patients. Findings show that generally patients felt they had been given enough information about their dental problem (95 per cent) and the treatment (85 per cent). Most people said that they understood the benefits of treatment (87 per cent), and that the dentist had explained things well (78 per cent).

However there were a number of aspects of their treatment that remained unclear for the patients who were interviewed. For instance 60 per cent said that they were not aware of any treatment options; 53 per cent of people were not clear about any risks that could be associated with treatment; 42 per cent were unclear about when they could expect treatment to be completed.

When respondents were asked about how decisions about their treatment had been made about half of them said that the decision had been a joint one with dentists and patients making the decisions together, but for the rest it was the dentist who decided about the treatment.

Consent to be treated was given verbally, or agreement was just assumed. The only occasion when a consent form was signed was when a general anaesthetic was required for a child or a vulnerable adult. Otherwise there was no specific signed consent to indicate any agreement about treatment that had been reached between the dentist and the patient.

One person described the way that he had consented to treatment:

> *He said is that all right? And I said that's all right, carry on.*

Another person commented:

> *I present myself and I sit with my mouth open, that's consent I suppose.*

That dentists may not ask patients if they consent to treatment is illustrated by this comment:

> *I wasn't asked, I just accepted it, I had toothache at the time.*

Box 4: Summary of responses from the people interviewed (N=60)

- 95% of the people interviewed felt that they had been given enough information about their dental problem; 85% said that they understood about their dental treatment; 87% understood the benefits of treatment and 78% said that dentists had explained things well.
- 60% said that they had not been told about alternative treatments and 53% had not understood any risks associated with treatment; 42% were not sure when they could expect treatment to be completed.
- About half of the patients thought that treatment decisions had been made jointly, 51%, whilst 49% felt that the dentist had made the decisions.
- Consent was always verbal or implied except when a general anaesthetic was required for very young children or adults with severe learning difficulties when a consent form was signed.

There were examples of good practice in providing patients with information. This was confirmed by the observations in the clinic, and the views expressed by both dentists and patients who thought that good information was given about dental problems and treatment. In this way dentists are meeting their legal obligations to give patients a broad outline of their problem and explain the proposed treatment, in order to avoid any charge of battery.

However this is an example where the law may not always be the best guide to good practice, since patients were less likely to have been told about alternative treatments or about potential risks. But it should be noted that this is information which is now increasingly being demanded in relation to negligence should something go wrong, and is stated in recent GDC guidelines.[1]

The picture that emerges from these findings about the practical realities of obtaining informed consent suggests that although patients are being well informed about their dental condition, people have not always understood the treatment options and risks which would enable them to be more fully involved in the decision-making process. In practice about half of the patients said that decisions had been made by dentists. Consent remains assumed rather than explicit and written consent forms are not widely used.

The suggested stages in the process of obtaining informed consent were not absent from the clinical situation. However the findings suggest that in the practical reality of the dental consultation these stages are not all routinely used. Neither do they follow a coherent or well-rehearsed pattern. The observations that were made in the clinic and the responses of both dentists and patients failed to demonstrate a consistency when obtaining consent – as for example taking a medical history did. This is further evidence of the fragmented approach to consent that currently exists in dentistry.

4. When consent presents a challenge

So far in the discussion it has been assumed that dentists and patients share a common language and that people are both competent enough and mature enough to give their own consent to treatment without any support from a third party. Now the more difficult issues of obtaining consent for those patients who may need an interpreter, adults who are accompanied by a carer, and children attending with their parents will be considered.

4.1 Language

In some places dentists may only occasionally meet patients who do not speak the same language, but in other parts of the country this is a difficulty that may arise more often.

A woman who wore traditional Indian dress attended the Dental Casualty Clinic. She was relaxed and well able to explain her dental problems to the dentist and to listen attentively to the information and explanation that she was given. She responded with nods and gestures as she engaged in the consultation. Another woman attending the Clinic wore a black veil and long black dress. She moved the veil covering her mouth so that the dentist could examine her teeth but she then covered her eyes with the veil. She spoke no English and was accompanied by her adult daughter. The male dentist who was speaking to her was tempted to speak loudly in an effort to aid communication. She communicated her dental problems using a finger to indicate the area that was causing her discomfort. The younger woman helped to translate as well as possible but there was very little direct communication between the dentist and the patient.

Adults from other cultures and who may not speak English are quite competent to understand and to make rational choices but they may be unable to do so because the dentist and patient do not have the usual means for verbal communication. This presents challenges to dentist and patient alike and causes worries on both sides about lack of common understanding or the dangers of misunderstanding. This may not be so difficult if the dental problem is a relatively simple one, but when treatment is complex then it becomes even more important for people to feel assured that they have sufficiently understood each other to be able to provide informed consent for treatment to proceed.

Two situations were observed: some limited shared language where time must be taken to ensure a patient understands, and no shared language at all where an interpreter is essential.

There were also other cultural barriers observed between dentists and patients, such as gender differences, differences in levels of education and economic and occupational differences. People from other cultures have different knowledge and different expectations about health and health care.

The experiences of dentists and cross-cultural communication

Trying to overcome language and cultural barriers may be difficult and demanding for dentists, requiring extra time and patience. Dentists said that they would most often rely on a friend or relative of the patient to translate (89 per cent), others would manage as best they could (8 per cent). Only a few would employ a professional interpreter (3 per cent).

Problems that dentists experienced when there was no shared language included:

- difficulties in obtaining a medical history
- difficulties communicating with relatives and interpreters
- being sure that the correct information was passed on
- being sure that information had been understood
- the additional time that was needed.

The experiences of adults who did not speak English

A Spanish-speaking woman who had lived in England for two years explained how she had practised the words in English before she came to the dental clinic.

> *I came with a paper from my dentist and I thought that with my small English they would direct me and tell me what to do.*

She explained how she had expected everyone to be English and how she would have needed to use sign language to point to the problem with her tooth. She felt she was helped by having a translator, a dentist who spoke Spanish.

One Bengali father who attended with his six-year-old daughter explained how he did not speak much English.

> *I understand a bit but not properly, it helps if the dentist speaks slowly and also shows me.*

He explained how he gave his consent for her treatment.

> *I agreed to treatment, no signing, I told him yes.*

A Somali woman attended with her husband and very young baby. She spoke very little English and her husband translated for her. She explained how she would have liked to have told the dentist more but was not able to. Language is a problem for her because everywhere she goes she needs someone to interpret for her. Her husband explained that it was difficult for him too because he also had some difficulty speaking the language.

A Turkish patient who had a problem with some bridge work brought his 16-year-old son.

> Son: *Some words the doctor says are, 'doctor words' and it's hard to translate them into normal words.*
>
> Interviewer: *What do you do then?*
>
> Son: *I ask the doctor to simplify it for me.*

One young Turkish man described his feeling of being lost without the language and how having a Turkish health advocate had helped.

> *It is much better for the health advocate to help.*

He explained how he was frightened and how he just wanted everything completed so that he could go.

Concerns expressed by patients when communication was difficult because of language included:

- toothache, *'When he has a lot of pain he can't concentrate'*
- clinical terminology, *'Sometimes long words are difficult'*
- unable to explain well, *'because he can't speak English he can't express himself'*
- uncertainty about understanding, *'I am not sure if I have understood or if they have understood me'*
- asking questions, *'It's difficult to ask things if you don't speak English'*
- getting correct treatment, *'I worried I would not get the right treatment'*.

The points raised by patients who do not speak English equally apply to others, especially in understanding highly technical and complicated medical language.

Obtaining consent will never be perfect because it concerns the understanding between two people. It can never be possible to understand the other person completely, nor to obtain completely informed consent. When there are cross-cultural differences the dentist must sometimes do the best that can be done to meet the patient's needs. In difficult situations health advocates are essential and much more use should be made of them. But there is always going to be some measure of compromise in the negotiation and there will always need to be trust between the people concerned.

4.2 Vulnerability

In a very real sense any patient attending for dental care is vulnerable, especially if they are anxious or in pain. However this section considers dependent adults.

One adult patient attending the Special Needs Clinic signalled her agreement to have her mouth examined by vigorous nodding and opening her mouth very wide. Her mother put her thumbs up to signal her own approval. One mother said to a new dentist, 'He's a bit iffy with strangers. He may not let you touch him.' In the event the patient, a man in his thirties, was happy to open his mouth and have his teeth examined. In an extreme situation the dentist may have their fingers bitten by a frightened patient who objects to being touched by a stranger. One 50-year-old woman attended the clinic with two care workers. She was invited to sit down but steadfastly refused to do so and backed up this refusal with violent shaking of her head. During the ten-minute visit she continued to stand and shake her head. In this situation the dentist respected her refusal, although this was difficult since carers had made considerable efforts to attend. Sometimes disability is so severe that full examination of the mouth can only be done under a general anaesthetic. One patient who required multiple extractions and fillings was put onto a waiting list, but this is a last resort and only used when no other means of treatment is possible.

Caring for adults whose ability to take care of themselves is limited by disability is very demanding, for it is not possible to make the usual assumptions about adult behaviour and understanding. At the same time it is important to honour the limited autonomy that people do have in matters of choice and consent. For dependent adults, relationships are made not only with patients but must include accompanying carers as well, for their support is crucial in gaining a patient's confidence and compliance. There is need for a flexible approach so that the dentist can adapt to the particular disability and needs of individual patients.

The clinic environment and details of organisation may not immediately seem to be part of consent but their contribution to creating an atmosphere of respect is very considerable and helps to involve patients and carers in their dental care. For example, the availability of seating for accompanying carers, keeping waiting time to a minimum, making sure that arrangements for follow-up appointments are made and efficient management of waiting lists, are organisational details that are important in all dental care but are especially so for people with learning disabilities and their carers.

Vulnerable adults may present particular dilemmas for dentists when making treatment decisions because they do not have the necessary comprehension or reasoning power that makes them legally competent to give consent for themselves.[15] Since in this country no adult may act as legal proxy for another adult, the clinician must proceed in the patient's best interests. When decisions are difficult a second professional opinion should be sought. This does not exclude involving carers in decision-making but the law gives the ultimate responsibility to clinicians. Many commentators acknowledge that this is a particularly difficult area and many practitioners continue with the practice of asking the carers to give consent.[16]

The experiences of dentists treating vulnerable adults

Dentists in practice see very few vulnerable adults. However they replied that when an adult was not competent to give consent for themselves they would ask the carer to give consent (79 per cent), although some would act in the patient's best interest and take responsibility for decisions for such patients (21 per cent).

Difficulties that dentists encountered when treating incompetent patients included:

- judging competence
- obtaining an adequate medical history
- difficulties in explaining
- communication with carers
- co-operation
- referrals
- the extra time that was needed.

The experiences of carers of vulnerable adults

One mother explained how the dentist had made the decisions.

> *I don't mind, they know what they're talking about. I just trust people. It's always been well before. I understand but I've got a brain like a sieve, sometimes I forget.*

She explained how she had other worries, her own health problems and concern for her daughter.

The mother of a 34-year-old patient who had Downs Syndrome explained that it was the dentist who made the decisions because her daughter would have said no to everything.

Steve is 44 and his mother is 66. He has very limited speech and goes to a training centre. His mother explained how she has to look after him from top to toe. The decisions had been made jointly by the dentist and the mother because:

> *Steve doesn't understand.*

Another mother also spoke of the difficulties vulnerable people have in obtaining dental treatment.

> *When she was a child we were chucked out of more dentists than we'd had hot dinners. They refused to treat her because of her epilepsy.*

It was observed in the study that it was the practice of the Special Needs Clinic to obtain a signature from carers for a general anaesthetic. Donna was going to be admitted for treatment under general anaesthetic and her mother explained how she had signed a form on her daughter's behalf. Jane, who was 52, had also required a general anaesthetic for her dental treatment. Her elderly mother was in residential care and there was some confusion about who should sign any consent form.

Concerns expressed by carers about information and consent included:

- not knowing patient's experience, *'Sometimes it's difficult to know whether or not he is in any pain with his loose teeth'*
- alternatives not explained, *'to begin with I had to raise the question of alternatives'*

- other things on the mind, *'Sometimes I go blank because of worry'*
- knowing what is best for another person, *'If I felt it went against her interests I would say so'*
- confusion over consent, *'I think one (a consent form) has been sent to his community home but I'm not sure'.*

Again these points mentioned for vulnerable adults are also more widely applicable.

With vulnerable adults it is important to respect the autonomy that a person does have, even though they may have multiple disabilities. Failing to do this can result in refusal to comply, or in the build up of unspoken resentments. However, co-operation can be achieved, despite the obvious difficulties, although this requires a great deal of professional skill, especially in the interpersonal skills and decision-making skills that are needed. Sometimes the moral background to dental care goes unnoticed. But characteristic of the Special Needs Clinic that was observed were the acceptance of disability, the recognition of limitations, and the goodwill of those involved.

4.3 Immaturity

About a third of the patients treated by dentists are children. They may be both nervous and vulnerable. Furthermore children have different levels of autonomy depending on their age and maturity.

As a dentist on the Children's Clinic examined a five-year-old boy she explained as she went along, 'I am going to use this little mirror, then I will count your teeth, keep open very wide, very good'.

A mother attended with her eight-year-old daughter and was advised that several teeth needed to be extracted. However the mother was reluctant to go ahead with the suggested treatment without consultation with her husband. The dentist made no effort to force a decision that day and another appointment was made so that both parents could attend.

A 12-year-old girl had a painful tooth removed. The options of a local anaesthetic or a general anaesthetic were discussed and whether to have treatment on the same day or to return. She opted to have a local anaesthetic and to have the treatment on the day of the consultation. The father, who was present throughout, gave his consent and the girl was warned not to inadvertently bite her lip whilst it was numb. The tooth was extracted in less than a minute and the drama minimised by skilful management by the dentist. Offering options and respecting choices was built into the management of the situation.

When obtaining consent for children there is a threefold relationship between the dentist, child and the accompanying parent who is legally responsible for their child. Clearly a very young child is not able either to understand or reason about their dental treatment, and consent to proceed must be obtained from parents. But as children grow older it is important that dentists respect their evolving autonomy, and for parents and children to be jointly involved in reaching decisions with the dentist. Adolescents increasingly take responsibility for themselves and may at times be able to make decisions without the support of their parents, a situation which is now recognised in law.[17] Those providing health care have the potential to nurture the growing autonomy of children as they face clinical intervention, they also have the potential to damage a child's capacity for self determination if they override their choices through authoritarian attitudes.

The experiences of dentists treating children

Most dentists said that they agreed that parents of young children should be present in the surgery (68 per cent). Then for older children, 66 per cent of dentists agreed that some older children are mature enough to consent for themselves. If a child refused routine treatment most dentists replied that they would wait rather than force treatment (91 per cent), others would use gentle restraint (4 per cent) or refer them (5 per cent).

Areas of difficulties noted by dentists in obtaining consent for children included:

- children attending without their parents
- decision-making for mature children
- poor co-operation
- disagreements about treatment.

The experiences of children and their parents

The mother of a four-year-old who had ten fillings said:

> *They explain everything and involve you. They explained things to him and made him feel confident.*

One seven-year-old commented on the value of explanations:

> *It's better that she does explain then I know what she's going to do.*

A nine-year-old girl who had been referred because she was very anxious explained how the dentist had shown her the dental equipment:

> *The dentist showed me the Hoover that sucks the water, but I didn't like the tippy chair.*

Her mother commented:

> *Being shown the tools and actually touching them herself has helped. She has gained a lot of confidence now.*

Parents felt that they had been able to express their concerns and to ask questions:

> *Every question I asked I got an answer to.*

Parents explained how they would ask questions if they needed to:

> *If I'm not satisfied I would ask, not just sit there.*

However one mother explained how as a parent she needed to make sure that she did ask questions:

> *You need to ask questions and be forthright otherwise it is assumed. I make sure I ask questions but there is no point in getting too technical.*

But parents sometimes felt hesitant about asking questions as this mother said:

> *I didn't feel I could keep asking questions.*

In about half of the cases parents felt that decisions about treatment had been made collaboratively, otherwise it was the dentist who decided about treatment. In many cases there remained an expectation that it was the specialist who would say what was to be done:

> *I know she's got to have it. It's nice to be told what they plan to do.*

But on other occasions patients had felt more involved in taking decisions:

> *It's all been decided together, not behind closed doors.*

One ten-year-old boy who was a regular patient attended for an emergency extraction of a primary molar. His mother explained that it was her child who had made the decision about having his tooth taken out with the dentist. After the tooth had been removed he said in a matter of fact way:

> *It was aching so I wanted to get it out so that it would stop aching.*

In those cases where a general anaesthetic had been required a consent form had been signed:

> *It was my husband who signed, I didn't want to be the 'baddie' in Andrew's book.*

But usually consent was verbal and often assumed:

> *The consultant made the decision about what needed to be done. I just agreed with it.*

Parents expressed some of the difficulties that they had experienced:

- assumptions that people understand, *'there was too much general assumption that I understood when I did not'*
- being seen by different clinicians, *'One thing we struggled with was seeing a different person every time'*
- not being able to formulate questions, *'I feel you don't always know what to ask'*
- appointments that are rushed, *'I haven't been told why she's having it done, it's so brief and quick, I cannot take it all in'*
- dentists automatically taking decisions, *'The dentist had already made up her mind about what should be done'.*

Children do not always fully understand their dental treatment or want to have it done.

> Interviewer: *Do you understand?*
>
> John: *I understand a bit.*
>
> Interviewer: *Did you want to have it done?*
>
> *John: No.*

However the following example describes how explanations can help an anxious child to accept dental treatment. Joe was frightened of the dentist even to the point of violence; he once gave his mother a black eye because he was scared.

Father: *Everyone put him at his ease here. We never thought he would do it. What helped was the general attitude of calm. Things were explained well to Joe so that he knew what was happening and was not left in the dark.*

Joe: *Understanding what they were saying made it easier.*

Father: *They came down to Joe's level but they did not talk down to him.*

Clinicians treating children were skilled in patient management and quickly developed a good rapport with child patients and parents. The fact that parents were present throughout meant that explanations did not have to be repeated. Dentists explained what was wrong and what they were going to do and often demonstrated this visually. The involvement of parents and children together in the consultation helped in obtaining consent because everybody knew what had been said and how agreement had been reached. However, as with adults, the process of obtaining consent for children that was observed remains one of explaining and doing rather than explaining and choosing.

5. Dentists' perceptions of the value of informed consent

The principle of informed consent was not an unfamiliar one to dentists and they described a number of very positive ways in which it was likely to be of practical value to patients, to dentists, and in forming good relationships between them.

In the questionnaire dentists were asked to agree or disagree with statements concerning decision-making in dentistry. Few agreed with a model of decision-making where the decisions were left entirely to the patient (15 per cent), or where the dentist alone made the decisions (23 per cent). The majority of dentists (80 per cent) thought that patients have the right to make their own decisions based on having the appropriate information (these were not mutually exclusive categories).

Box 5: Models of decision-making in dentistry (N=234)

- 15% of dentists agreed with the statement, 'I think that dentists should provide whatever treatment patients ask for providing that they can afford it and that it is technically possible.'
- 23% agreed with the statement, 'I think that dentists should make the decision about what dental treatment should be done because only they have the expert knowledge.'
- 80% of dentists agreed with the statement, 'I think that patients have the right to make their own decisions based on being given information about their clinical condition and the available treatment options and any risks.'

Providing information gives patients both knowledge and understanding of their situation before they agree to any dental treatment. As a result people gain a greater insight into their dental health, they are then likely to be more satisfied with their treatment, and they become more interested and more motivated to look after their own health in the future. There is a value for the patient in having the opportunity to put their concerns into words, as the dentist becomes a listener both reach a more complete understanding of the clinical situation. Clinicians thought that informed consent could reduce anxiety:

> *I am sure it would decrease anxiety if they knew what was going to happen and they had a chance to ask questions or discuss things.*

Clinicians' perceptions of the practical value of informed consent for patients included that it creates greater awareness, gives a chance for concerns to be voiced, increases empowerment, enhances dignity, increases motivation, increases satisfaction and reduces anxiety.

Box 6: The practical value of informed consent

For patients

- creates greater awareness
- voices concerns
- offers choices
- increases empowerment
- enhances dignity
- increases motivation
- increases satisfaction
- reduces anxiety

The clinicians interviewed also spoke of the value to dentists of obtaining a person's informed consent to treatment, as one said:

> *I think we need it and are better clinicians for it.*

Being accountable to another person heightens awareness and any initial proposals may be changed or adapted in the negotiation to more nearly meeting the needs of the other person. One clinician described how having to explain something in straightforward terms to a patient helped him to clarify his own understanding of the situation, what could be done and how and when it could be done, and how this new understanding was then fed back into the treatment planning process. This engagement helped to make treatment planning more realistic. Two comments illustrate how dentists believe that informed consent increases compliance:

> *I think if you have got a more informed patient and they are more aware of why you are doing things, they are more likely to comply with treatment because they understand it much more.*

And:

> *A benefit I think would be to the dentist. It would definitely increase compliance if patients knew and were able to understand. They might feel they have responsibility for their treatment and that it doesn't solely depend on the doctor.*

It was further suggested that, by increasing co-operation and compliance, informed consent might save the dentist time and expense in the long run:

> *I think that would benefit us because then we would have less people not turning up for appointments, and after the initial barrier we might find that appointments are shorter because patients feel more confident and comfortable ... At the end of the day it would be cost effective.*

Obtaining informed consent helps to prevent any misunderstanding:

> *A patient who is involved in decision-making is less likely to be awkward later.*

And:

> *The time taken to get informed consent is worthwhile to avoid misunderstanding and possible ethico-legal problems.*

Dentists thought the practical value of informed consent for themselves included that it acts as clarification, encourages realistic treatment planning, improves co-operation and compliance, saves time and money in the long run and avoids litigation.

Box 7: The practical value of informed consent

For dentists

- acts as clarification
- encourages realistic treatment planning
- improves compliance
- increases co-operation
- saves time (and money) in the long run
- avoids litigation

Dentists and patients should be consenting partners who both know what is going on and the progress that can be expected. This establishes good relationships. By providing information and choice, and then specifically inviting consent a dentist can help to avoid any blind acceptance of professional opinion by patients, which fosters more mature and more equal relationships and a sharing of responsibility.

Informed consent establishes a relationship where:

> *... the patient is making choices, not so much the dentist saying this is how it should be.*

Informed consent is important because it gives people greater power over their own situation. This is how one dentist described her ideas about the value of informed consent in professional relationships:

> *Apart from being absolutely necessary I think it has educational value. If you talk to people as you are gaining consent you will be giving them information. Ignorance is the big enemy and if people have information they then become empowered to change.*

Dentists thought that informed consent helps to establish mutual understanding and common aims, shares responsibilities, promotes confidence and trust and fosters more mature relationships between dentists and patients.

Box 8: The Practical value of informed consent

For dentist–patient relationships

- increases mutual understanding
- establishes common aims
- shares responsibility
- promotes confidence and trust
- fosters mature relationships

Expectations are changing; there are more treatment options available as dental technology improves. At the same time dental treatment is getting more expensive and litigation is increasing. What was accepted conduct 30 years ago is now being challenged. One dentist contrasted the paternalistic attitudes of the past with a more interactive approach to consent. In the past clinicians made a decision, without telling the patients about alternatives and would go ahead in what they considered were the patients' best interests. Whereas now the different possibilities would be explained, together with their complications and the consequences of doing nothing. An example would be in the very difficult management of facial cancer and the decision whether to do a radical resection, or whether to provide palliative care. These days the patient is much more likely to be the one who makes the final decision.

The need for better training in obtaining consent was raised by one dentist who still remembered his acute embarrassment at having to obtain consent for major surgery as a houseman when he would not be doing the operation and what little he knew about it he had to read up the night before.

One view might hold that informed consent is primarily important to avoid problems. Although avoiding litigation was mentioned as one possible benefit of informed consent, it was but one reason in a long list of other benefits that are of practical value in the provision of dental care.

The dentists interviewed identified many positive benefits to be gained from taking informed consent seriously, for patients and for themselves and in the more mature professional relationships that are established. Consent was seen as much more than protecting the dentist. It made a real contribution to good professional practice and the quality of care provided. The following comments summarise what they thought about informed consent.

Box 9: What dentists thought about informed consent

- *I think it is related to the dignity of the patient, they are not just someone who sits there with their mouths open they have involvement in what is going on, and they have a moral right to understand and to consent. But beyond that it takes them into the realms of partnership.*
- *I think the underlying philosophy, not only of informed consent but for any treatment, is the old biblical phrase, not to do to anybody else what you wouldn't like done to yourself. You have to ask yourself if you were in the chair with all your dental knowledge is that what you would like done to your tooth.*
- *For me it's trying to ensure that patients are given the relevant facts in a way that they can understand and then to make a decision that they feel happy with... it's as simple as that and as difficult as that.*
- *I think it is the whole ethos of making sure all parties understand what is going on.*
- *I think it is ensuring that the patient has understanding and control over what is happening to them. But it works both ways because it ensures understanding and control on both sides.*
- *I think by it's nature it implies a two-way process by which anyone who is going to have something done to them is made aware of all the implications and is given the opportunity to express their own feelings about it and so influence what might be done, even to the extreme of saying no.*
- *The words springing to mind are mutual communication and equality, both parties must have an equal understanding of whatever procedure is being consented to.*
- *I suppose that it is so patients become stakeholders in their care, I think that's it.*
- *I think it is about motivation. Any treatment has to be something patients perceive to be beneficial to them. It's not something they are doing for someone else.*

- *It's a patient's right, like the right to privacy and the right to freedom.*
- *Yes, I think it's being totally fair to the patient.*
- *I think it is so that the patient really does know what is going to be done for them and that they want to be an equal partner in the management. This can take the burden off you because you then share.*

6. Discussion: making consent more explicit

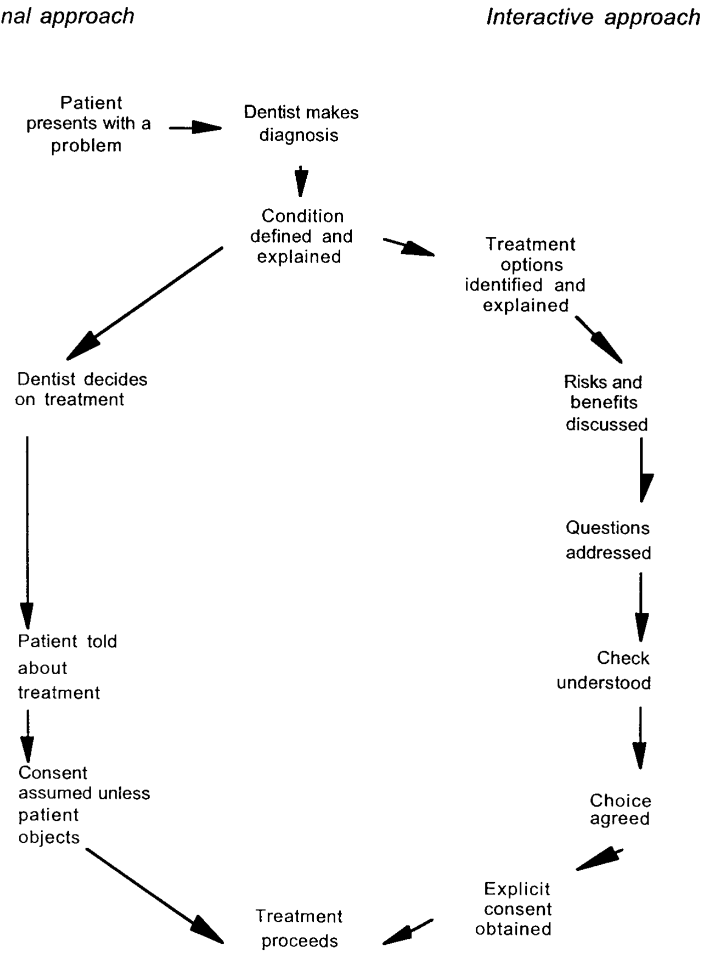
In the past it has been the dentist who considered the clinical possibilities and decided on the best course of action for the patient. There was little expectation on either part that patients would take any active part in decision-making. Consent, if it was explicitly obtained, was tacked on to the end of the consultation process rather than being an integral part of it. This study shows that this pattern of practice is still common. Practice, however, is changing. More consideration is being given to the need for consent.[18] Patients want more information.[19] But at the same time there remains a good deal of confusion about how consent is obtained in practice.[20] Involving the patient more fully by providing information and offering choices is becoming more widely recognised as being the proper way to proceed. There is a real possibility that a well-structured procedure for obtaining consent could be developed and become a routine expectation in any dental consultation, in the same way that a medical history is routinely checked. This way consent becomes explicit.

From this research it is possible to discern two different approaches to consent, a traditional approach and an interactive approach. Both approaches start with the person deciding to attend the dentist. The dentist examines the patient and forms a diagnosis. The dentist can then describe to the patient what has happened and explain the problem. Hereafter two different routes to consent may be taken.

In the traditional approach the dentist now proceeds to consider in their own mind the possible treatment options. By applying their specialist clinical knowledge and experience and weighing up all the possibilities, they reach a clinical judgement about the way forward for the patient. Having worked out what they think is the best treatment this is then explained to the patient in terms of what the dentist plans to do. Unless the patient makes an objection to the dentist's suggested treatment, their consent is assumed and treatment proceeds.

In the interactive approach the dentist may open up another and more interactive route to consent by first telling the person about the options that are available, including the option of no treatment. By giving a patient this clinical information the way is opened up for choices to be considered together by both patient and dentist. Without this information the patient remains in the dark, often having no idea of what treatment options might be available. The process must then include a discussion about the advantages and disadvantages of each treatment option, including possible risks and complications, any costs and considerations of time involved, as well as the expected benefits. Questions may be asked and understanding clarified on both sides. Now choices can be made and the dentist can seek the patient's informed consent for treatment to proceed. With this approach decisions are based on appropriate information and are made jointly by both dentist and patient, creating a more equal partnership between them. Consent is negotiated and made explicit rather than remaining assumed. These two routes to consent are described in the following diagram.

Figure 1: Two routes to consent

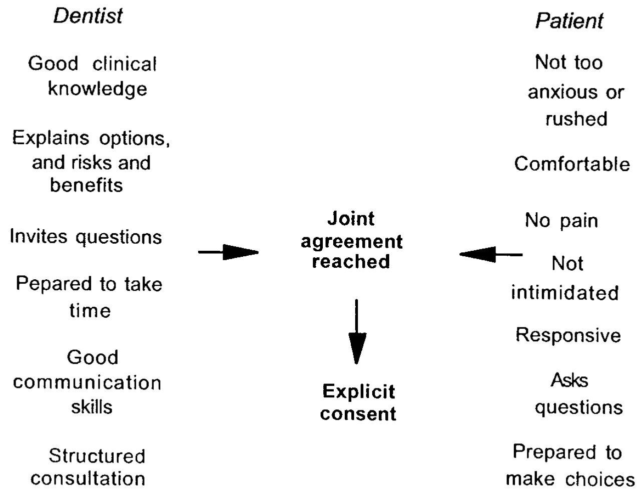


In both cases the process ends up with agreement for treatment to proceed, but the two routes are significantly different. These differences have important implications for the kind of relationships that are established. The first route is based on a paternalistic trust of the professional to make the right judgement and acceptance by both parties that the dentist knows what is the best treatment. The second route however is a way of involving a person in what is happening in their own mouths. Rather than simply being told what is going to be done the patient is invited to consider the alternatives and thereby take a fuller part in the consent process. The relationship which is established by an interactive approach to obtaining consent means that decisions, and therefore responsibilities too, are shared between the patient and the dentist.

Whether or not an interactive approach is taken will depend on dentists being prepared to provide information about options and risks and patients being prepared to engage in making decisions. However the patient cannot make choices unless they are offered the information and the opportunity to do so.

The study has suggested that there are a number of factors that might help to make consent more explicit. The dentist needs to have the required clinical knowledge and confidence to be able to offer realistic options so that choices are clear. They must have good communication skills and take the necessary time to invite questions. The process of consent must be a deliberate and structured part of the consultation. Then the patient must ask questions and make choices. They should feel comfortable and not be hampered by pain or undue anxiety. They should not feel intimidated or rushed. The language used should be simple and free of technical jargon. The factors that help to make consent more explicit are illustrated in the diagram below.

Figure 2: Factors making consent more explicit



These remarks concern those situations where dentists and patients share a common language and culture and where adults are capable of giving their own consent. This might be described as the 'normal' situation. However when there is no shared language, or when adult patients are not competent to make their own decisions, or for dependent children there is a different situation and there are additional dynamics in the consenting process.

Obtaining informed consent is an important consideration in health care for ethnic minority groups.[21] When a person does not speak the same language an interpreter should be sought whenever possible.[22] Cultural biases and preconceptions must be put aside if effective communication is to take place between people from different cultural backgrounds. Furthermore the differences in power between patients and dentists must be recognised.[23, 24] Taking informed consent seriously is one very important way in which these inequalities can be addressed. The dentist must be willing to listen and to adapt.

There is a need to repeat information and to keep explanations as simple as possible and to give people the confidence to use any limited language that they do have. Much can be achieved with patience and a willingness to persevere.

Vulnerable adults with severe learning difficulties do not have the legal competence to give their own consent to treatment. The moral and legal difficulties that are raised in making decisions for vulnerable patients are explored in Buchanan and Brooks' account *Deciding for Others*.[25] In English law this is the only instance where clinicians must make decisions for conscious adult patients acting in their best interests.[26] However clinical practice has not always caught up with recent changes in the law, for instance a carer was asked to sign a consent form and most dentists in practice would still ask the carer to give their consent. This is an example of how working practice still adheres to old procedures in spite of changes in the legal position. However it undoubtedly remains good practice to involve the carer in planning treatment. Making decisions on behalf of others who are vulnerable means carefully weighing up alternatives and trying to be sure of always acting in a patient's best interests.

There is now general agreement that children should be more actively involved in making decisions about their health care than in the past,[27] although this remains a contentious issue for some clinicians.[28] An interactive approach to informed consent involves parents and children as fully as possible in the process. This means developing a structured approach and making a deliberate effort to open up the consultation to allow children and their parents to participate. The way that consent is sought involving children and parents together plays a significant part in good patient management and can help children to feel in control of their treatment and as a result reduce anxiety and encourage co-operation.

Consideration of those groups of patients where consent presents particular problems is interesting in the light that it throws on the consenting process generally. The challenge of difficult communication situations brings fresh insights into what might help people to understand each other better and give their consent more freely. For example, small amounts of information given slowly, using simple words and visual explanations helped when the dentist and patient did not speak the same language. Familiarity with the clinical environment and continuity of care was an important factor for vulnerable adults and their carers. Parents and children explained how time taken to give them appropriate explanations helped children to gain confidence and feel less anxious. Explanations may not need to be very lengthy or complicated but they do need to be well timed using words that the other person can understand. This applies to all patients although they assume even greater importance when there are particular problems to be overcome.

It cannot be said from the observations in this study that dentists do not provide information, or that treatment proceeds without the patient's agreement, in the legal sense of the word, but the process of obtaining consent is not carried out systematically nor is it made explicit in the consultation. The patient may tacitly agree to the dentist's proposals but often without an awareness of alternatives or any associated risks of treatment. The reasons for the present fragmented approach to consent which this study has highlighted are complex. But there are some possible underlying causes. It has traditionally been the expectation of both dentists and patients that decisions are made by the dentist and that a patient's consent is assumed. In addition there is a lack of regulatory guidance and professional education about the ethical and legal aspects of good practice, although in its new guidelines the GDC[1] does now place much greater emphasis on maintaining high ethical and legal standards. Then in the NHS fee structure, resources are not specifically allocated to pay dentists for the time they spend talking to patients.

In this study salaried dentists and those working privately were found to spend twice as long obtaining consent as dentists working in the General Dental Services. This suggests that there are serious pressures of time for dentists in NHS practice. The question of the cost of spending time informing patients about treatment alternatives is recognised as an issue by Christensen.[29] There is a tension in dentistry between the need to complete technical procedures efficiently and the desire to spend time talking to patients. Offering preventive advice is another area where dentists would like the fee structure to give more recognition to the educative role that dentists have. Any discussion of the importance of informed consent must recognise that the time taken to educate patients needs proper recognition in the way that dentists are paid. It is no good implying that dentists should spend time obtaining informed consent if the structures are not in place to enable them to do so effectively.

The variety of approaches to consent that were observed in this study suggest that this is a time of transition, moving away from the paternalism of the past to a more interactive approach. As dentistry moves towards creating more partnership in clinical relationships, consent will become a much more active process than it is at present. This is important in respecting personal autonomy and the good relationships that result. It is a fundamental human right, as one of the children taking part in this study said:

> *I'd rather be involved because it's me they're doing it to.*

The aim should be that obtaining informed consent becomes an integral part of the dental consultation in a deliberate and systematic way. Just as it is important to create an environment that is physically comfortable, so too is it important to create an environment where people feel morally comfortable, and respect for another person's capacity for self determination is always a moral priority in health care. Respecting autonomy by obtaining patient consent in health care is much more than a matter of professional ethical or legal obligation, or even of good professional practice. It respects the basic human need[30] to be a self-determining person. As such it has an essential value in promoting human wellbeing.

7. Conclusions and recommendations

The study of consent in dental care shows that the principle of informed consent is generally acknowledged by dentists to be of value. Many examples of good practice have been identified. However there is a wide variation in current practice. At the outset it was proposed that nine component stages in the consenting process were routinely used in the dental consultation. This hypothesis was not supported by the findings. Although the individual stages could be identified they were not always used and did not form a coherent pattern. The main conclusion from this study is that there is not a well-structured approach to consent in dentistry. Much is assumed and remains unclarified. This was so in all four of the patient groups that were studied.

7.1 The consenting process

According to observations in the clinic and replies from the responding dentists and patients, good information about the patient's dental condition was likely to be provided by dentists. However treatment options, risks and benefits were less likely to be discussed. Although about half of the patients interviewed felt that decisions had been made jointly, for the other half decisions were made by the dentist alone. Written consent was sometimes used but was not the expectation for either dentists or patients. Consent was most often assumed rather than made explicit. Dentists estimated that the average time spent providing information and obtaining consent was seven minutes. Dentists in practice were uncertain about the status of the NHS Claims form, many erroneously thinking that it was a consent form. There was limited use of the Treatment Planning form, although it is required by NHS regulations.

7.2 Where consent presents a challenge

Although there are times when patients and dentists come from different cultures and do not speak the same language, health advocates were not normally available to help with translation. For vulnerable adults clinicians were uncertain about the present situation for consent and the legal concepts of competence and the principle of no adult proxy were not always clear. Parents and children were likely to be involved in the consultation but, as with adults, options and choices were not always offered or consent made explicit.

7.3 Awareness of the value of informed consent

Dentists described many theoretical benefits of informed consent. As dentists become more aware of the principles of informed consent and put those principles into practice in chairside consultations, they have an important role in creating more equal partnerships in clinical relationships by encouraging patients to take a greater part in the consultation and to be more questioning before they give their consent to be treated. There is a need to make the ethical and legal principles of good consenting practice more widely understood by both the professionals who provide and the people who receive dental care.

7.4 Recommendations

General recommendations

1. Consent should be made explicit in the dental consultation rather than remain assumed.

2. A systematic approach to obtaining consent to dental treatment should be an essential part of all treatment planning (similar to the expectation that a medical history will always be taken). This should follow a defined series of stages.

3. There should be an interactive approach to deciding about dental treatment. People should be offered choices and explanations about the advantages and disadvantages of the different ways that their dental care might be managed.

Recommendations for NHS general dental practice

4. The status of the NHS Dental Claims form must be clarified and consideration given to the potential for developing and increasing the use of the existing Treatment Planning form, and to developing a useable and patient friendly consent form.

Recommendations for particular groups of people

5. There should be more understanding and co-operation with the work of health advocates when people speak another language.

6. There needs to be more clarification for clinicians and also carers of the legal concepts of incompetence and no adult proxy for vulnerable adults.

7. There should be an increasing awareness of the evolving autonomy of children and the need to respect their maturing capacity for consent.

Recommendations for education

8. Further training is needed in the practical moral and legal aspects of obtaining consent at the chairside for dentists at undergraduate and postgraduate level.

9. Ways must be sought of raising general awareness of peoples right to information, choice and consent in all aspects of health care.

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