Records: Do They Justify The Treatment Provided?

When poor or unexpected treatment outcomes occur, patients often allege that the treatment was not necessary or that they were inadequately informed of the risks and possible consequences associated with treatment.

When matters like these are reported to the Professional Liability Program (PLP), in addition to determining whether or not the treatment met the standards of practice expected of an Ontario dentist, there are other questions that PLP needs to address.

The first is whether or not the treatment in question was clearly justified by the entries in the patient record. The second is that we need to establish whether or not the records documented adequate communication with the patient during the informed consent process.

To illustrate these issues, let's look at two similar practice situations with very different results.

QUESTIONS ABOUT A PARTICULAR SITUATION?

If you have questions about how to handle a particular situation with a patient, do not hesitate to call the College.

PLP Claims Examiners

416-934-5600 • 1-877-817-3757

Practice Advisory Service

416-934-5614 • 1-800-565-4591

PLP POINTERS

Remember, courts generally take the view that if it isn't in the records, it didn't happen. Your records are your best defence!

Before treating a patient, the following information should be documented in the records:

- **chief complaint and presenting symptoms**
- **clinical signs**
- **results of any tests performed**
- **radiographic findings**
- **diagnosis or diagnoses**
- **nature of recommended treatment**
- **discussion of nature of recommended treatment as well as risks, benefits, alternatives and costs**

CASE No.1:
Treatment Not Justified in Records – Case Not Defendable

Ms. F presented to Dr. K for recall, and at that appointment Dr. K replaced a restoration in tooth 17. The following day he replaced restorations in teeth 25 and 26.

Two weeks later Ms. F returned with cold sensitivity in tooth 17 and Dr. K performed endodontic treatment.

Ms. F initiated a small claims court action alleging Dr. K had unnecessarily replaced fillings in three teeth simply because her dental insurance was about to be terminated. She claimed the teeth were asymptomatic and Dr. K had told her there were no problems with her teeth. Ms. F alleged it was the unnecessary restoration in tooth 17 that caused the need for root canal treatment.

DISCUSSION

In reviewing Dr. K's records, PLP staff had a number of concerns.

The radiographs, clinical notes and treatment records did not support the need for replacement of the restorations in teeth 17, 25 and 26. This made it difficult to determine whether the restorations in question were indeed necessary.

Likewise the radiographs and the records did not support the need for endodontic treatment of tooth 17. There was no evidence that Ms. F had any symptoms other than cold sensitivity. There was no record of any clinical tests and there was no documented diagnosis or discussion of treatment options. In other words, there was no evidence that informed consent for endodontic treatment had been obtained.

PLP recommended settlement of the claim as treatment could not be justified by the records and there was no documented informed consent. Dr. K agreed.

PLP negotiated a settlement amount and obtained Ms. F's full and final release in favour of Dr. K. This release stated specifically that Dr. K had not admitted liability.

Records: Do They Justify The Treatment Provided?

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CASE No. 2:
Treatment Justified in Records – Case Defendable

Mr. C presented to Dr. W for a new patient examination and Dr. W recommended replacement of two amalgam restorations. She replaced a restoration in tooth 45 on that date. One week later she replaced the amalgam in tooth 16.

Two weeks later Mr. C returned with pain in tooth 16 and Dr. W performed endodontic treatment. One month after that, tooth 45 was endodontically treated as well.

Mr. C subsequently filed a claim against Dr. W alleging the restorations in teeth 16 and 45 were unnecessary and the treatment was negligent, resulting in the need for root canals on both teeth. He further alleged the root canal treatment was poorly done and retreatment of both teeth was necessary.

Additional Resources Online at www.rcdso.org

- **Risk Management Guide**
- **Guidelines on Dental Recordkeeping**
- **Informed Consent: A Guide to Understanding the Consent Process in the Dental Office (LifeLong Learning program)**

DISCUSSION

PLP was able to defend this case because:

- The records and radiographs clearly showed there was deep recurrent decay in both teeth 16 and 45. Replacement of the restorations was warranted.
- Radiographs taken prior to endodontic treatment showed the restorations were well placed.
- The records showed that, prior to initiating endodontic treatment on both teeth, Dr. W performed standard tests, appropriately diagnosed irreversible pulpitis and discussed treatment options, risks and benefits. In other words, the records clearly showed that endodontic treatment of teeth 16 and 45 was necessary and informed consent was obtained.

Final radiographs of teeth 16 and 45 showed the canals were well filled to the apices.

FINAL COMMENTS

Often, when a patient presents, the dental problem is obvious and the treatment needed is clear, both to the dentist and to the patient. However, as these case studies illustrate, it is important to keep in mind that if things go wrong with the treatment, the patient may allege the treatment was not necessary. The records must be able to demonstrate that the treatment was required and informed consent was obtained.

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Some observations about staying safe

What has Don learned about dentists in his decade as director of the Professional Liability Program? "Most dentists in Ontario strive to provide their patients with appropriate, effective, up-to-date, safe and ethical dental health care, but for various reasons, some do sometimes miss the mark," said Don. After viewing thousands and thousands of PLP files over those years, what insights does Don have to share?

- **Most patients are reasonable, appreciative and understanding – a few are not.**
- **Some dentists are poor communicators and even poorer listeners.**
- **Some patients are poor listeners and timid communicators.**
- **The majority of disputes with patients can be minimized or resolved when a caring, interested and problem-solving approach is used.**
- **Many disputes escalate into formal complaints or lawsuits when practitioners appear to be rigid, too busy to listen to a patient's problems and unwilling to discuss and/or provide reasonable and reasoned solutions.**

Power of Personal Communications

Poor communications is the common thread to disputes with patients. It is crucial to be more pro-active in your personal communications with patients. That means not relying so much on office staff to shield you from dealing with patient concerns. If an untoward incident arises, patients need to be advised, an apology given, if appropriate, and steps taken to rectify the situation either by you as the treating dentist or by referral to another practitioner.

Good records are a dentist's best friend and bad ones are his/her worst enemy. The courts take the view that if information is not in the patient's records, it didn't happen. That is why it is important to keep detailed and accurate treatment records, following the College's Dental Recordkeeping Guidelines. And these records need to include a record of all discussions/interactions with your patients.

"There is no question that patient threats or the actual commencement of legal action for compensation for unsatisfactory results or a mishap or accident are stressful events in any dental practice," acknowledged Don. "However, there are tried and true preventative strategies that PLP has seen prove their worth time after time after time."

Follow the Informed Consent Process

Review the informed consent process that is used in your practice to ensure that the discussion is done in a systematic way and is accurately recorded. Take the time necessary to provide your patients with sufficient information to allow them to make an informed treatment choice. Need a tutorial? Brush up by viewing the College's LifeLong Learning program, Informed Consent in the Dental Office.

Records, Records, Records

Retain your patients' original records according to the record retention standards of the College. Only provide copies when requested to do so by the patient or his/her authorized representative. It is also important to make sure that any new staff member is made aware of this requirement. Copies of the College's recordkeeping guidelines are available for viewing online at www.rcdso.org for both you and your staff.

Mistakes Do Happen

Sometimes even the best dentists in the world make mistakes. The key is to have strategies in place in your practice to prevent or minimize mishaps; for example, checking that the rubber dam is on the correct tooth, making sure that you have the patient's current chart and most recent radiographs before beginning treatment, isolating teeth properly when potentially caustic materials are being used, etc. It is also important that when mishaps occur, material safety data sheets, for example, are readily available.

Know Your Comfort Level

Recognize your limitations and treat within your comfort level. And when a referral to a specialist or more experienced practitioner is warranted, confirm the accuracy of the referral by personally reviewing all written referral letters or notes for completeness before making the referral appointment.

LifeLong Learning

Develop a personal continuing education plan that is tailored to your practice needs and, where possible, periodically plan courses that involve some hands-on components.

FINAL WORDS…

Keep your patients' best interests in mind at all times. Aim always to provide treatment that is according to current standards and, above all, enjoy your chosen profession.

Treating a Medically Compromised Patient

In the course of your professional career, you will regularly encounter medically compromised patients. These patients have special medical and/or dental needs that could directly impact their medical condition. The following case from the Inquiries, Complaints and Reports Committee (ICRC) illustrates how difficult treatment decisions become when a patient is medically compromised.

An elderly patient, 82 years old, presented with a significant medical history, including coronary artery disease and the use of many medications. She wanted extensive treatment involving her upper crowns and made clear her choice was replacement, not repairs, as the treatment was largely for esthetic reasons. During the treatment discussion, she seemed knowledgeable about dental matters. She was asymptomatic and appeared to be medically under control.

The treatment plan was discussed, including at least two appointments for work-up and consultation, as well as the cost of over $13,000. The patient was provided with a written estimate and a treatment information form. Since the patient needed help to get to the appointments, she asked the dentist to perform the treatment over a shortened period of time. The dentist agreed.

Her initial treatment appointment lasted five hours, during which eleven crowns were prepared. This long appointment included at least one hour for lunch and several brief breaks. The dentist used five carpules of local anesthetic, administered in intervals as he worked on individual teeth. The treatment

appeared to go smoothly and the patient did not report any post-treatment discomfort.

About three weeks later, the patient returned for another appointment that was about two hours long. This time the member used two carpules of anesthetic. Again the patient took a number of short breaks during the treatment. After the appointment, the dentist was not contacted about any complications or concerns.

Unfortunately, only one week after the second treatment appointment, the patient died of a stroke.

A complaint from the patient's representative followed, in which it was alleged that the dentist:

- did not properly advise the patient of the high stress associated with the treatment she wanted;
- did not inform the patient that the treatment was potentially fatal;
- did not offer to perform the treatment during a number of shorter appointments;
- administered too much local anesthetic, given the patient's age and medical history;
- provided unnecessary treatment.

During its review of the complaint, the ICRC panel sought the opinion of an expert in dental anesthesia. The expert's opinion was that the two hour appointment was acceptable, but the five hour appointment was inappropriate for a patient with cardiac illness. In addition, during this appointment, the dentist had not monitored the patient's blood pressure and heart rate properly.

However, the expert said that, although much of the treatment could be considered unnecessary, ultimately the dental treatment could not be linked to the stroke suffered by the patient one week after the treatment was completed.

Despite the expert's conclusion, the panel was concerned about the dentist's management of this patient as there was a failure to record some of his discussions with the patient and it was not clear that she had received sufficient information about the treatment. Also, the records did not provide clear justification for the treatment.

The panel concluded that, when a medically compromised patient is being treated, particularly if that treatment is extensive, the dentist must take great care to obtain and document the patient's informed consent to treatment.

...when a medically compromised patient is being treated, particularly if that treatment is extensive, the dentist must take great care to obtain and document the patient's informed consent to treatment.

The panel also noted that the dentist allowed the patient to dictate treatment, instead of using his professional judgement to determine the timing and duration of the appointments.

The complaint was resolved when the member agreed to refresh his knowledge of proper recordkeeping practices and to take a course in the treatment and management of medically compromised patients.

Professional Decisions Need to Respect Patient's Needs and Personal Preferences

A 79-year old woman comes to your dental office. She says her health is good and amazingly is on no medications. You check her blood pressure and heart rate and they are normal for a person of her age.

Your clinical examination shows multiple teeth missing. The remaining teeth show moderate periodontal involvement with generalized pockets of mild bone loss. She has one necrotic tooth that needs extraction. Her periodontal problems are not severe, but overall the patient does not exhibit good oral hygiene.

She says she lost a set of partial plates a couple of years ago. So now she wants you to make permanent bridges so she won't have to worry about losing another set. You have a thorough discussion with her about your treatment recommendations and she gives consent. But she asks you to speak with her son.

The conversation with her son does not go as well. He bluntly states that his mom is "losing it." He doesn't want any money spent on what he calls "expensive" treatments. He says she is old and he wants you to take out all her teeth and make her a set of dentures.

This scenario might soon be commonplace for most dentists.

In Ontario, the number of seniors aged 65 and over is projected to more than double from 1.8 million, or 13.9 per cent of population, in 2010 to 4.1 million, or 23.4 per cent, by 2036. This acceleration in the share and number of seniors is projected to increase over the 2011–2031 period as baby boomers begin to turn age 65.

... if our patient is capable of making decisions, then we need to respect his/her wishes.

What is at stake here is the ethical principle called autonomy. Autonomy is one of the core values in the College's Code of Ethics. It is the moral basis for the informed consent process. Competent people have the right to make decisions about what they want to have done to their bodies. If we believe that our patient is capable of making decisions, then we need to respect her/his wishes.

As a professional health care practitioner, our obligation is to always act in the best interests of our patients. To do that means that our professional decisions must respect patients' values and personal preferences.

Patients must be informed of possible complications, alternative treatments, advantages and disadvantages of each, costs of each, and expected outcomes. Together, the risks, benefits, and burdens can be balanced. It is only after such consideration that the best interests of our patients can be assured.

Health care practitioners need to be alert to the influence of our assumptions or misconceptions about our patients' capacity to participate in informed decision-making about their treatment. Most elderly patients are extremely capable and motivated. Despite contrary stereotypes, most elderly patients are competent.

Of course, advanced age does not negate the legal and ethical necessity of obtaining informed consent from competent patients. To facilitate communication, family members or other third parties may take part in the decision-making process. But the patient, if capable, must make the actual decision. Even if there is a power of attorney document in place for health care decisions, if the patient still has capacity, then the patient can consent on his or her own behalf.

It is important to document all informed consent discussions and decisions thoroughly. If the patient makes what you consider an unwise choice, document your attempts to persuade the patient otherwise. And, if the patient asks you to practise below the standard of care, you should refuse.

The fundamentals of dentistry remain the same no matter the age of the patient. As the principles of the Code of Ethics state: "The paramount responsibility of a dentist is to the health and well-being of patients."

But dealing with older patients may call for an extra measure of awareness, sensitivity and commitment to clear communication. By making these adjustments, you can provide the safe, high-quality care that this large and growing group of patients needs.

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Take care to properly obtain and document informed consent

The issue of informed consent to dental treatment is encountered frequently in complaints reviewed by the Inquiries, Complaints and Reports Committee (ICRC).

In many cases, the patient complains that if she had all of the facts about the proposed treatment, she would not have proceeded. On the other hand, the dentist complained of will often assert that, even if there is scant or no notation of the informed consent discussion in the patient chart, the discussion did take place and the patient properly consented to the treatment rendered.

The patient had treatment performed on her upper anterior teeth. She complained that the dentist failed to inform her of the nature of the treatment to be performed. Also, once treatment had started, the dentist had continued even though the patient asked her to stop. The patient later requested that the treatment be reversed.

The patient also reported that she experienced various complications from the treatment, including sensitivity in her upper anterior teeth, difficulty chewing and fused teeth.

At a following appointment planned to discuss the patient's concerns, the patient noted that the dentist admitted fault for any misunderstanding. However, the patient remained unsatisfied as she felt that not all of her concerns, particularly about cost and long-term complications, had been addressed adequately.

THE PANEL REMINDED THE DENTIST OF THE REQUIREMENT TO BOTH DISCUSS AND DOCUMENT THE PATIENT'S INFORMED CONSENT TO TREATMENT.

In responding to the complaint, the dentist explained that, after examining the patient, she noted the patient's bruxism habit and recommended treatment on several upper incisors. Following that initial examination, the patient asked the dentist's staff if she needed to return for additional treatment and was informed that she needed to return for fillings. According to the patient, neither the cost nor the nature of the treatment was explained to her.

The patient later returned for the planned treatment. However, during the procedures, the patient became uneasy and asked the dentist if she was receiving fillings. To her surprise, the dentist said that she was not, as she did not have caries. The dentist then explained that she was adding composite material to the patient's teeth in order to protect the existing tooth structure. At that point the patient advised the dentist that she did not want the treatment and the dentist reversed the treatment by removing the material that had been added to the patient's teeth.

In her response to the complaint the dentist explained that she had recommended restorations because several of the patient's anterior teeth were worn on the incisal edges. She also said that the treatment and the reasons for it were discussed fully before any of the procedures were initiated.

In reviewing the complaint, a panel of the Inquiries, Complaints, and Reports Committee noted that there appeared to be some misunderstanding about the term "filling." The patient appeared to believe that a filling is performed when a tooth is decayed and needs to be restored. However, the dentist noted that the patient did not seem to be aware that adding composite resin to a tooth to protect it, although the tooth may not be decayed or carious, is also a normal part of restoration procedures.

In addition, there was no notation in the dentist's records about an informed consent discussion with the patient. While the patient appeared to believe that fillings are only used to treat caries, the dentist clearly understood that restorations are also used to treat other dental conditions.

The panel pointed out that despite the miscommunication, the treatment planned and initiated by the dentist was entirely appropriate. However, the panel did remind the dentist of the requirement to both discuss and document the patient's informed consent to treatment.

Accordingly, the panel took no further action after offering and accepting the dentist's undertaking/agreement to take a course in record keeping, including informed consent. The undertaking/agreement included a monitoring component of twenty-four months, to ensure that the lessons learned in the recordkeeping course would be implemented in the dentist's practice.

Best interests of the patient do not negate the need for informed consent

All dentists know the importance of having and documenting informed consent discussions with their patients. This complaint illustrates that even when a dentist does not harm the patient and acts in the patient's best interests, the informed consent discussion is always a necessary part of the process in advance of providing dental treatment.

A patient complained that the dentist initiated root canal therapy without his consent. The patient indicated that on at least two occasions before the appointment in question, he had advised the dentist that he would not consent to root canal therapy because he believed that it would be very painful.

The patient attended the dental office for an examination and the dentist recommended restorations for several teeth in the upper left quadrant. The patient agreed to have the restorations done at his next appointment and said that he did not wish to have root canal therapy. At the second appointment, the dentist began the restorations as planned. However, the patient fell asleep during the treatment. It was the dentist's view that the treatment could still be completed safely if the patient were allowed to sleep.

> THE PANEL PROVIDED THE MEMBER WITH PRACTICE ADVICE AND DETERMINED THAT THE DENTIST WOULD BENEFIT FROM A REVIEW OF THE COLLEGE'S LIFELONG LEARNING PROGRAM ON INFORMED CONSENT IN THE DENTAL OFFICE.

As the treatment progressed, and as the dentist removed carious tissue from a tooth with deep decay, there was a carious exposure. The dentist decided that there were only two options for treating the tooth: root canal therapy or extraction. The sleeping patient was already frozen, and the dentist performed a pulpotomy to prevent the patient from experiencing any pain.

When the treatment on all teeth was completed, and the patient awoke, he asked the dentist to describe what had been done. The dentist then informed the patient that one of the teeth had required a pulpotomy, and that the procedure was performed to prevent the patient from being in pain. The dentist also informed the patient that the procedure would provide him with time to consider his treatment options. The patient was unhappy with this explanation and complained that the pulpotomy had been performed without his consent.

The dentist explained to the Inquiries, Complaints and Reports Committee panel that, in performing the pulpotomy, he was trying to do what he believed was in the patient's best interests. The dentist also wanted to give the patient time to decide what further treatment he wanted for the tooth.

The panel agreed that the treatment was indeed in the best interests of the patient, that it was reasonable for the dentist to perform the treatment and that the patient was not harmed. Nevertheless, the panel expressed concern that the member did not first obtain the patient's informed consent to perform the pulpotomy.

The panel noted that the patient could have easily been awakened to obtain the required consent, and that the dentist should record all such consent discussions.

The panel provided the member with practice advice and determined that the dentist would benefit from a review of the College's LifeLong Learning Program on informed consent in the dental office.

Children and consent to treatment

PLP and the Practice Advisory Service often receive enquiries about who can consent to dental treatment on behalf of a minor patient. The following information will assist members in ensuring that proper authorization is obtained before dental services are performed on a child.

A health practitioner must assess the decision-making capacity of a child before proceeding with treatment.

GENERAL PRINCIPLES

Except in an emergency, a health practitioner must obtain consent from a patient before providing treatment. According to Ontario's Health Care Consent Act, 1996 (HCCA), in order to be valid, that consent must:

- relate to the treatment in question;
- be informed;
- be given voluntarily;
- not be obtained through misrepresentation or fraud.

The patient must also be capable of consenting to treatment. According to the HCCA, a person is capable of making a treatment decision if he or she understands:

- the nature and purpose of the treatment;
- the consequences of giving or refusing consent.

A health care professional is entitled to rely on a presumption of capacity, unless there are reasonable grounds to believe the patient is incapable with respect to the proposed treatment. Since capacity is not only specific to the patient but also to the treatment in question, the same patient may be capable of consenting to some services and not others.

PROFESSIONAL LIABILITY PROGRAM
ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

Children and consent to treatment

AGE OF CONSENT

Notably, though it does establish a presumption of capacity for persons aged sixteen or older, the HCCA does not prescribe a minimum age for consenting to treatment. Therefore, as with all patients, a health practitioner must assess the decision-making capacity of a child before proceeding with treatment.

Factors to consider in determining whether a child fulfills the criteria for capacity set out in the HCCA include the patient's age, level of maturity and the type of treatment in question.

Very young children would not normally meet the test, while mature minors may be capable of consenting to minimally invasive, routine procedures and adolescents may be able to validly consent to more complex or elective treatment. However, since an agreement to pay by someone under the age of eighteen may not be enforceable, it is unwise to act on a minor patient's instructions alone, except in an emergency.

A capable child may also refuse treatment. If a young patient is able to understand why the treatment is required, what is involved and what is likely to happen if he or she declines, the health care provider is obliged to respect the child's wishes, even if the parents disagree. Indeed, failure to do so may give rise to allegations of civil battery or criminal assault.

Health professionals are well-advised to ensure that the person providing consent has that authority.

An incapable minor's parents or guardian can make treatment decisions on the child's behalf and are required to act in his or her best interests in making such determinations.

SEPARATED OR DIVORCED PARENTS

Generally speaking, custodial parents have full parental rights, while access parents have the right to receive health information about children of the relationship but not to give or withhold consent to treatment. Therefore, while

health care providers should usually have the consent of both parents with joint custody before treating an incapable minor, they may be able to take instruction from an attending joint custodian or rely on the consent of a sole custodian alone.

However, these basic rules can be amended by agreement or court order, and health professionals are well-advised to ensure that the person providing consent has that authority and that no other person needs to be consulted or notified, particularly if the proposed treatment is complex or invasive. The safest way to achieve this is to obtain a written statement from the parents outlining who may make treatment decisions for the child, as well as what information the practitioner should convey to and receive from each parent and by what means.

Where both parents must consent to treatment, the document should also describe how the agreement of the non-attending parent will be communicated to the health care provider. If the parents are unwilling or unable to provide joint instructions, it may be wise for the treating practitioner to request a copy of the custody agreement or court order before relying on the authorization of one parent.

You can find more e-brochures that highlight risk management topics relevant to the profession and other PLP resources on our website at
http://www.rcdso.org/MemberResourceCentre/RiskManagement

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ADVICE FROM PLP

PLP trial outcome: nerve damage following third molar extraction

The extractions were complicated due to the depth of the impactions and orientation of the teeth, but tooth 48, which was completely fused to the jaw, proved especially challenging.

Mr. D was a 39-year-old accomplished bagpiper who was referred by his general dentist to oral and maxillofacial surgeon Dr. M for possible third molar extraction. The patient told Dr. M that his general dentist had seen "fluid" under the 48 two months before. Dr. M diagnosed pericoronitis of teeth 38 and 48, both of which were impacted and mildly tender without exudate. Dr. M recommended extraction of those teeth and the 28 as well, the 18 having been removed previously.

In light of the patient's age, Dr. M warned him of the risk of sinus damage relating to the 28 and nerve injury arising from the lower extractions. Because he had personally observed a jaw fracture during wisdom tooth removal early in his career, he also advised the patient of that possibility. His notes of the consent discussion read:

Op; complications; sequelae explained, esp re poss sinus exp or nn injury or injury to adj. teeth or jaw #

The patient returned eight weeks later and signed a form consenting to the proposed treatment. Dr. M's operative note states:

Extn of 28, 38, 48 c IV Sed – GA + LA via buccal flaps at all 3 sites c bur bone removal at all 3 sites & splits of 38 & 48 & indep retrieval of (ankylosed) roots from dense bone at all 3 sites

The extractions were complicated due to the depth of the impactions and orientation of the teeth, but tooth 48, which was completely fused to the jaw, proved especially challenging. During its removal, a jaw fracture with minimal displacement occurred and was immediately reduced with internal wire fixation and arch bars. Mr. D's jaw was wired shut for approximately eight weeks. While the fracture healed without complication, he was left with permanent numbness of the lower right side of his jaw, chin and lip and could no longer play the bagpipes competitively.

PROFESSIONAL LIABILITY PROGRAM
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Dr. M's defence was greatly assisted by the quality of his consent discussion and record-keeping, and because he had invariable protocols to which others in his practice could attest.

Mr. D and his wife brought an action against Dr. M alleging absence of informed consent and negligent technique. He was supported by the opinion of a general dentist who concluded that the fracture itself was proof of excessive force and improper sectioning and, based on Mr. D's evidence that the possibility of jaw fracture or numbness was not disclosed by Dr. M, that the patient's consent was not informed. In his view, while the risk of mandibular fracture causing nerve damage would usually be too remote to be considered a material risk, the fact that this particular patient played a wind instrument created a heightened duty to warn.

An expert oral and maxillofacial surgeon retained for the defence opined that Dr. M's work-up, diagnosis and treatment of the patient met the standard of care and his consent discussion actually exceeded what was required since jaw fracture during third molar surgery occurs too rarely to be disclosable. He also noted that the number of sections into which a tooth is cut and the force needed to perform an extraction are matters of judgment and that mandibular fractures and numbness can occur with wisdom tooth removal despite proper technique.

The matter proceeded to trial more than six years after Dr. M's treatment and, in reasons for judgment released in September 2012, the trial judge dismissed the action with costs to the defendant.

The judge accepted that Dr. M's contemporaneous notes accurately reflected the risks disclosed to Mr. D, including the possibility of numbness and fracture. He also accepted the testimony of Dr. M and his nurses that Dr. M's invariable practice was to give such warnings to patients undergoing third molar extraction and to record those conversations. He found that the extractions were necessary and discounted Mr. D's evidence that, had he known of the risks, he would have declined the surgery as being inconsistent with his history of following dental advice. Mr. D's claim not to have read the consent form before signing it was further proof of his willingness to leave himself in Dr. M's hands. In any event, the benefits of the treatment outweighed its risks, and a reasonable person, even one who played the bagpipes, would have consented.

As for the allegations of negligent technique, the judge preferred the opinion of the defence expert over the plaintiffs' on all points. He found the plaintiffs' expert report lacking in substance and criticized the expert for basing his assessment of the standard of care solely on his own experiences and rendering an opinion without properly reviewing the evidence. He noted that the defence expert had superior qualifications and grounded his opinion in statistical data rather than subjective impressions.

The plaintiffs' appeal to the Court of Appeal of Ontario was dismissed with costs in March 2014 and leave to appeal to the Supreme Court of Canada was not sought. The action is therefore concluded.

Dr. M's defence was greatly assisted by the quality of his consent discussion and record-keeping, and because he had invariable protocols to which others in his practice could attest. Without those things, the outcome of this case could have been different, despite the fact that Dr. M's care was entirely appropriate.

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RISK MANAGEMENT

Professional liability

In addition to being the subject of a patient complaint, a dentist who fails to obtain a patient's informed consent to treatment or to otherwise provide care in accordance with the standards of the profession may be held civilly liable.

Patients may turn to the courts for compensation. In Ontario, the legal system applicable to such situations is called the common law of tort. Common law is judge-made law and a tort is a civil wrong.

Torts may be intentional or unintentional. Conducting a procedure with no patient consent could be prosecuted as an intentional battery and could also be criminally actionable as an assault. Accidentally performing the wrong intervention, providing care without fully informing the patient of its risks, benefits and alternatives and failing to meet the standard of care in executing treatment all fall under the law of negligence as an unintentional tort.

Because of the deliberate nature of the conduct giving rise to an action for battery, a patient does not have to prove damage in order to be entitled to receive compensation for treatment performed with no authorization at all. Negligence occurs as a result of inadvertence and is considered less morally blameworthy than intentional wrongdoing. Therefore, a patient seeking damages for negligent dental care must show not only that the treating practitioner breached the applicable standard of care, but also that the patient suffered injury as a result (referred to as causation).

There are two categories of dental negligence, also called malpractice: absence of informed consent and negligent treatment, each with its own test.

There are two categories of dental negligence, also called malpractice: absence of informed consent and negligent treatment, each with its own test.

In order to prevail in an action for alleged failure to obtain informed consent, the patient must show that the health-care provider did not disclose all of the information required to make a fully informed treatment choice and that, had that information been provided,

Generally speaking, the causation issue is resolved by considering whether a reasonable person in the patient's position would have declined the treatment with full disclosure.

a non-negligent complication would have been avoided. Expert evidence is usually required to determine what the patient should have been told about the procedure and whether there were any alternatives that would have obviated or significantly mitigated the risk that materialized.

Generally speaking, the causation issue is resolved by considering whether a reasonable person in the patient's position would have declined the treatment with full disclosure. Obviously, if the therapy was necessary and/or other options carried the same, similar or heightened risks, causation will be hard to establish, and the action will not likely succeed despite the breach of duty.

Negligent treatment covers all other aspects of a health-care intervention, including patient selection, treatment planning, execution and after-care. In an action for alleged dental negligence, a patient must usually have as evidence an opinion from an expert outlining the relevant standard of care and stating that the defendant breached that standard. The patient must also convince the court that, but for the defendant's wrongdoing, injury would not have occurred. Failure to prove any of these elements is fatal to the claim for compensation.

Patients may also commence legal proceedings against dentists for breach of contract. The allegations in such cases often overlap with negligence claims, in which case the analysis of liability is similar. The outcome of a contract case involving only financial arrangements, not quality of care, turns on proof of the terms of the agreement rather than expert evidence.

Most legal actions for alleged defects in treatment against Ontario dentists are withdrawn without payment, some are settled and few go to trial. Under the Regulated Health Professions Act, 1991, any regulated health professional in Ontario against whom a finding of professional negligence or malpractice has been made must report the finding to the registrar of his or her college. This would include a decision by a trial judge that a dentist was negligent in treating a patient but not a judgment against the dentist in a purely financial dispute.

Since March 2014, all regulated health professionals in Ontario are legally required to have malpractice protection. RCDSO has been providing that protection to all of its members since 1973 through its Professional Liability Program (PLP).

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PROFESSIONAL LIABILITY PROGRAM
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PLP E-BROCHURE SERIES

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Common complaints and how to avoid them

The College processed more than 600 complaints and inquiries last year, many of which have common themes. Communications issues are some of the most frequent matters that come before panels of the Inquiries, Complaints and Reports Committee.

The College understands that a dentist never wants to be the subject of a complaint. Improved communication is one step that can go a long way to help resolve patient concerns and potentially avoid a complaint ever being filed. Here are some tips on how to avoid four of the most common concerns we see in the complaints arena regarding communications issues.

Remember, though, that even if you do find yourself the subject of a complaint, the College complaint process is designed to be transparent, impartial, and fair to both parties throughout. And always remember to notify the Professional Liability Program of any circumstances that may result in a claim against you.

#1 "The dentist never warned me this could happen!"

One of the most common complaints arises when complications occur during a procedure or when a dental treatment subsequently fails. An endodontic instrument separates and can't be removed. A tooth develops irreversible pulpitis following a deep restoration. A crown fractures at the gum line.

The College understands that negative treatment outcomes can occur even when the treatment rendered was appropriate and in keeping with the standards of practice. However, it is important to inform patients of such possible negative outcomes in advance as part of your informed consent discussions.

The chance of a negative treatment outcome should never be a surprise for a patient. A patient is far less likely to complain when treatment fails if they have been forewarned that this could be a possibility. The less of a surprise, the less likely a patient is to file a complaint. Of course, if a negative outcome does occur, the patient should be advised immediately and that discussion should be documented.

It is important, therefore, to take the time in advance of treatment to clearly explain the possible negative outcomes and their consequences, and to clearly and comprehensively document such conversations as part of the clinical record.

#2 "The treatment was far too expensive!"

Patients can often be surprised by the cost of dental treatment, even where such costs are reasonable and reflect the profession's prevailing rates. A patient may be shocked to learn that what they thought was "just a few fillings" can add up to hundreds or even thousands of dollars worth of dental bills. Taking the time to explain costs to a patient in advance of treatment can help to prevent sticker shock and a potential complaint after the fact.

Though dentists may not always enjoy discussing the financial side of their practice, explaining the cost of proposed treatment is an integral part of obtaining a patient's informed consent. Providing a formal quotation for expected costs or sending out a predetermination to an insurance provider is always a good idea when treatment is extensive or expensive. Even providing a rough estimate for more routine treatment, with appropriate provisos, can help a patient understand how much they are likely to be charged.

It is also good practice to explain clearly to patients what factors may have an impact on costs. For example, the presence of decay under a crown can lead to the need for further treatment and increase the potential cost.

#3 "The dentist didn't even listen when I had a problem..."

Sometimes all a patient wants is for someone to listen to their concerns. Being a sympathetic ear to a patient's concerns and setting out steps for how to address them can sometimes alleviate those concerns entirely. Practise active listening skills to help patients understand that you have heard and understand their concerns, even if you may disagree with them. Taking the time to listen before speaking will often save you much more time and trouble in the long run.

Not only will improved communication with patients and a little common sense help you avoid being the subject of a formal complaint to the College, it will also help you establish and maintain long-lasting professional relationships with your patients.

#4 "The dentist was so rude to me!"

Maintaining professionalism in stressful circumstances, such as dealing with a dissatisfied or even angry patient, can be difficult, but it is one of the hallmarks of professional practice. Speaking in an even and respectful tone, not showing signs of irritation or frustration, and not responding in kind to rude behaviour from a patient are absolutely key to good professional communication. It is also good practice to document any challenging discussions with a patient in a detailed, contemporaneous notation. Having any other staff members who witnessed or overheard any such patient interactions document their own observations, is also a good idea.

In addition, when responding to a formal complaint filed with the College, it is equally important to maintain a professional and respectful tone. Your response is being read by a panel made up of dentists and appointed members of the public who are tasked with regulating the profession in the public interest. Keep your audience in mind when writing your response, and never write when you are angry or upset – it will come across in your response.

Not only will improved communication with patients and a little common sense help you avoid being the subject of a formal complaint to the College, it will also help you establish and maintain long-lasting professional relationships with your patients.

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RISK MANAGEMENT

Informed consent to treatment

Canadian law recognizes the fundamental right of every mentally capable person to accept or refuse health care regardless of its risks or benefits. It is also acknowledged that, without sufficient information about proposed treatment, a patient cannot make an educated choice, rendering this right of self-determination effectively meaningless.

Dentists and other health practitioners are sometimes confused about how much and what kind of information must be provided in order to ensure patients are able to make fully informed health care decisions. The following describes the basic principles of the law of informed consent to treatment in Ontario.

The duty to disclose

The foundations of the Canadian common law of informed consent were established in 1980 when the Supreme Court of Canada held that health practitioners have a pre-treatment duty to answer a patient's questions and to disclose information that a reasonable person in the patient's position would want to know before consenting.

The particulars of this duty are now codified in Ontario's Health Care Consent Act, 1996 (HCCA). Specifically, subsections 11(2) and (3) of the HCCA state that, in addition to having their questions answered, patients are entitled to be informed about:

1. the nature of the treatment
2. the expected benefits of the treatment
3. the material risks of the treatment
4. the material side effects of the treatment
5. alternative courses of action
6. the likely consequences of not having the treatment.

RCDSO also requires its members to discuss the direct and ancillary costs of treatment with patients as part of the disclosure process.

Material risks

It is worth noting that patients need not be advised of every risk associated with proposed treatment for consent to be informed, only material ones. As a general rule, risks are considered material if they occur frequently, even if the consequences are minor (e.g. temporary pain or numbness), or if the consequences are significant, even if they occur rarely (e.g. paralysis or death). That said, because patients are

less likely to accept risks associated with unnecessary procedures, even less consequential risks may have to be disclosed in order to obtain a patient's fully informed consent to elective treatment.

Materiality may also depend on a patient's unique circumstances: a concert flautist would likely be more concerned about the possibility of even transient oral paresthesia than the average patient, creating a heightened onus of disclosure for the treating dentist.

While treatment providers cannot know every detail of their patients' lives, the scope of the duty to warn in any particular case is determined by what the health professional did know or would have learned about the patient in the ordinary course of taking a history.

In addition, a health care provider cannot be wilfully blind to indicia that a specific patient may have reasons to be concerned about a risk that might not otherwise be considered material.

Obtaining consent is not a single event, but rather a process that occurs over time.

Causation

In the regulatory context, an inquiry into a patient complaint of absence of informed consent focuses on whether the health practitioner met standards of disclosure and record-keeping.

But a breach of the standard of care is only one of the elements that must be proved for a health care provider to be held civilly liable for malpractice. To succeed in an action for negligence, the patient/plaintiff must also demonstrate on a balance of probability that the defendant's wrongdoing caused his or her injuries.

Where the claim is based on an alleged failure to warn, the plaintiff must persuade the court that the risk that manifested itself was material and knowing about it would have led a reasonable person in his or her position to decline the treatment. If, out of necessity or by choice, a reasonable patient would have consented to the procedure despite its risks, the breach of the duty to warn caused no harm.

This is not to say that a practitioner who wrongly caused a known risk of a procedure to materialize cannot be held liable for a patient's losses, since the acceptance of material risks does not equate to a waiver of liability for negligent treatment.

Evidence of consent

A signed consent form is one piece of evidence that information was disclosed to and discussed with a patient and the patient agreed to treatment. However, obtaining consent is not a single event, but rather a process that occurs over time. And since a legal action for alleged absence of informed consent can be brought years after the treatment was completed, health professionals should supplement written consent forms with clear documentation of each consent discussion in their patients' charts.

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Challenges in treating patients in a long-term care facility:

Informed consent and recordkeeping

The dentist should assess a patient's capacity each time informed consent is sought. A patient's ability to provide informed consent may depend on his or her condition that day or on how complicated or extensive the planned treatment is.

Providing dental treatment and oral care in a long-term care (LTC) facility can present unique challenges. Dentists who work in LTC facilities must still meet the standards of practice: they must ensure that the available physical facilities are adequate, keep dental records that adhere to the RCDSO's guidelines, and obtain informed consent before initiating any treatment. Obtaining informed consent in LTC facilities can be particularly challenging and warrants careful analysis.

Due to dementia and other conditions that result in cognitive decline, some patients cannot understand information relevant to making a decision about treatment or appreciate the reasonably foreseeable consequences of a decision about treatment. Such patients are incapable of providing informed consent for treatment.

If a patient is incapable, the Health Care Consent Act, 1996, allows a substitute decision-maker to provide the required informed consent. The substitute decision-maker could be, for example:

- an individual granted the Power of Attorney (POA) for Personal Care;
- the patient's spouse, child, or other family member;
- an individual appointed by the provincial Consent and Capacity Board.

The dentist should assess a patient's capacity each time informed consent is sought. A patient's ability to provide informed consent may depend on his or her condition that day or on how complicated or extensive the planned treatment is.

Dentists cannot assume that a patient who has named a POA for Personal Care is incapable of providing informed

consent on his or her own behalf. In fact, the patient had to be capable in order to grant the POA for Personal Care.

Dentists should be aware that a caregiver sometimes attends a dental appointment with a capable patient and may provide information about the patient's health history. If that occurs, the dentist should still obtain informed consent directly from the patient.

The normal principles of informed consent apply when obtaining consent from a substitute decision-maker. Informed consent discussions should precede treatment and include the nature, risks, benefits and costs of the proposed treatment, treatment alternatives, including no treatment, and any other relevant information. The patient and the substitute decision-maker must have an opportunity to ask questions and to have those questions answered. If the treatment plan changes, the dentist must obtain informed consent from the substitute decision-maker for the amended treatment plan.

To facilitate discussions with substitute decision-makers, it is recommended that dentists collect contact information that can be used to reach substitute decision-makers on short notice, such as cell phone numbers or email addresses.

All informed consent discussions, including the efforts made to contact a substitute decision-maker or the circumstances leading a dentist to believe a patient could not personally provide informed consent, should be carefully documented in the records.

OTHER RESOURCES

Ontario Dental Association Informed Consent Course
www.youroralhealth.ca (available through the ODA member portal starting January 2016)

RCDSO Practice Advisory Service FAQs
http://www.rcdso.org/Members/PracticeAdvisoryService

Practice Advisory:
Informed consent issues including communication with minors and other patients who may be incapable of providing informed consent
http://www.rcdso.org/KnowledgeCentre/RCDSOLibrary

Guidelines: Dental Recordkeeping
http://www.rcdso.org/KnowledgeCentre/RCDSOLibrary

Legislation:
Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A;
www.ontario.ca/laws/statute/96h02

Substitute Decisions Act, 1992, S.O. 1992, c. 30
www.ontario.ca/laws/statute/92s30

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RISK MANAGEMENT

Obtaining consent for treatment of an incapable adult

Dentists know that they must obtain informed consent before providing treatment to a patient. Who may provide valid consent, however, is not always clear. As a threshold matter, a dentist must determine whether a patient is capable of consenting to the proposed treatment.

When are patients capable of providing valid consent?

According to Ontario's Health Care Consent Act (HCCA), patients are capable of consenting to treatment if they are able to understand the information relevant to making a decision about a proposed intervention and to appreciate the reasonably foreseeable consequences of consenting to or refusing treatment. Patients are presumed to be capable unless there are reasonable grounds to believe otherwise.

Because capacity is specific to the patient and the treatment, a patient may be capable of consenting to some procedures and not others. Capacity can also wax and wane: a patient who requires medication to stabilize a mental health condition may be capable when compliant but unable to understand information about or appreciate the consequences of accepting or declining treatment when not medicated. Similarly, patients suffering from dementia may at times be able to provide valid consent.

Because capacity is specific to the patient and the treatment, a patient may be capable of consenting to some procedures and not others.

Under the HCCA, a patient who is found to be incapable has a right to appeal that finding to the Consent and Capacity Board. If the patient does not challenge the finding of incapacity or if it is upheld by the Board, someone other than the patient must provide consent before treatment can proceed.

Who may provide consent on behalf of an incapable patient?

A person who is authorized to make treatment decisions on behalf of an incapable patient is called a substitute decision-maker (SDM). The HCCA provides a hierarchical list of those who may act as an SDM:

1. Guardian of the person (under the Substitute Decisions Act)
2. Attorney for Personal Care
3. Representative appointed by the Consent and Capacity Board
4. Spouse/partner
5. Child/parent
6. Parent with right of access
7. Sibling
8. Any other relative (by blood, marriage or adoption)

Consent must be obtained from the highest ranked person on the list who is at least 16 years of age, capable, available and willing to give or withhold consent to treatment on the patient's behalf.

How does an SDM decide whether to provide or withhold consent?

An SDM must act in accordance with the incapable person's "advance directive", if any, i.e. wishes expressed by the patient when they were over 16 years of age and capable with respect to the treatment. Otherwise, the SDM must act in the patient's best interests, taking into account:

1) The values and beliefs the SDM knows the incapable person held when capable and believes they would still act on if capable.

2) Any wishes expressed by the incapable person with respect to the treatment that do not qualify as advance directives.

3) Whether the treatment is likely to:
   a) improve the incapable person's condition or well-being;
   b) prevent the incapable person's condition or well-being from deteriorating;
   c) reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.

4) Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.

5) Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm.

6) Whether a less restrictive or less intrusive treatment would be as beneficial as the proposed treatment.

A health practitioner who does not believe an SDM has complied with these requirements may ask the Consent and Capacity Board to direct the SDM to act in accordance with patient's advance directive or in the patient's best interests, failing which the SDM's authority may be revoked.

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Dealing with patients who wish to dictate treatment

From time to time, patients may present to your office with demands for treatment that, as a dentist, you know are not in their best interest. Some may have exceedingly high expectations that you feel are unrealistic and cannot be achieved, while others may request treatment that is beyond your expertise or comfort to provide.

It is a dentist's responsibility to take the time to properly engage their patients in the informed consent process and provide them with evidence-based information about all reasonably available treatment options.

Some patients may decline the treatment you recommend due to financial limitations, lack of knowledge or personal opinions for which there is no generally accepted scientific or empirical basis. Some may even try to dictate the materials and/or methods used for treatment, which may be inconsistent with the standards of practice.

Common examples of situations that dentists may encounter in their practice include patients who:

- decline diagnostic radiographs because of the associated cost, but still expect an accurate diagnosis;
- refuse radiographs that are required for treatment, such as root canal therapy or extractions, due to concerns about radiation;
- request the extraction of healthy teeth, which they feel are the cause of a systemic condition;
- decline local anesthesia before an invasive procedure, because of apprehension about needles;
- request the removal of sound amalgam restorations, due to concerns about mercury toxicity;
- refuse treatment for existing periodontal disease, but still expect extensive restorative work;
- express desires for exacting cosmetic results, like those of a particular movie star;
- decline a referral to a specialist for reasons that are related to cost or convenience, and then request complicated treatment that is beyond their general dentist's expertise or competence.

In this digital age, patients have ready access to clinical information from numerous sources, such as websites and social media. They may believe that they have the appropriate knowledge and judgement to take control of their dental health by directing which treatment they wish to receive and even how it should be performed. Of course, not all sources of information are equal in terms of reliability and completeness.

It is a dentist's responsibility to take the time to properly engage their patients in the informed consent process and provide them with evidence-based information about all reasonably available treatment options. This genuine effort may prompt some patients to reconsider their requests and, hopefully, accept their dentist's recommendations.

As a health care practitioner, you naturally strive to meet your patients' expectations and address their concerns. Understanding and respecting the autonomy of patients, there may be times that you feel pressured to accede to their demands. While patients have the ultimate right to make informed decisions based on their personal values and beliefs, you should be wary of demands that appear to be unreasonable and potentially harmful if carried out.

It is important to note that the following are acts of professional misconduct under the Dentistry Act, 1991:

- contravening a standard of practice or failing to maintain the standards of practice of the profession;
- treating or attempting to treat a disease, disorder or dysfunction of the oral-facial complex that the member knows or ought to know is beyond their expertise or competence;
- recommending or providing an unnecessary dental service.

While patients have the ultimate right to make informed decisions based on their personal values and beliefs, you should be wary of demands that appear to be unreasonable and potentially harmful if carried out.

The following advice will assist you in meeting your professional, legal, and ethical obligations, while still respecting a patient's autonomy.

1. Consider the merits of the requested treatment and whether it may harm the patient or is likely to fail. In some cases, the requested treatment may not be the ideal option or the one you would choose, but it does not breach the standards of practice and offers a clinically acceptable solution.

2. If a patient requests treatment that is not ideal, but that you determine is reasonable, you should clearly inform the patient of the risks and limitations associated with this treatment. You should also ensure that the patient has realistic expectations about the potential treatment outcome.

3. If the patient is requesting treatment that you judge to be below the standards of practice and/or you believe is not in the patient's best interest, you should NOT provide that treatment. Explain your reasons for refusing treatment.

4. If a patient requests treatment that is beyond your expertise or you do not feel comfortable providing, you are NOT obligated to provide that treatment. Explain your reasons for declining treatment. You may offer a referral to one or more specialists in the appropriate fields and let the patient decide whether they will proceed with the referral.

5. If a patient refuses to accept your treatment recommendations, such as the taking of radiographs that are required for treatment, explain the rationale for the recommendations and consequences associated with the refusal. If you feel that the patient's refusal compromises your ability to provide appropriate treatment according to the standards of practice, do NOT provide the treatment.

6. If a breakdown of the patient-dentist relationship occurs, you may decide to dismiss the patient from your practice. You will find the proper protocol for dismissing a patient in the August/September 2010 issue of Dispatch, which is available on our website www.rcdso.org in the Knowledge Centre.

It is very important to document the informed consent discussion in the patient's chart. This documentation may be critical in the event of a formal patient complaint to the College or lawsuit.

It is important to remember that you have a fiduciary relationship with your patients, which creates a legal duty to act solely in their best interests. Although a patient may wish to dictate treatment and offer to sign a release document or waiver in order for you to proceed with their request, you should keep in mind that this will not absolve you of your fiduciary duty or protect you from liability.

Of course, each case is unique and needs to be evaluated on an individual basis. If you require further guidance about a particular situation, please contact the College's Practice Advisory Services.

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PEAK SUMMARY

Informed Consent: From Material Risks to Material Information

The law of consent in the health care context has evolved significantly over time. Our society is no longer satisfied with the old paternalistic attitude that the "health professional knows best." Instead the autonomy of the patient now has priority. The underlying principle is the right of the patient to decide what, if anything, should be done with their body. A patient's consent to proposed treatment must be sufficiently informed. This enables them to choose whether or not to agree to the treatment.

If a patient is not properly informed about the nature of the proposed treatment, its risks and alternatives, a dentist may face civil liability in a case where the procedure leads to complications.

Dentists have both a legal and an ethical duty to ensure that their patients provide informed consent to proposed treatment. If a patient is not properly informed about the nature of the proposed treatment, its risks and alternatives, a dentist may face civil liability in a case where the procedure leads to complications. In addition, a dentist's failure to obtain informed consent from a patient may result in a finding of professional misconduct.

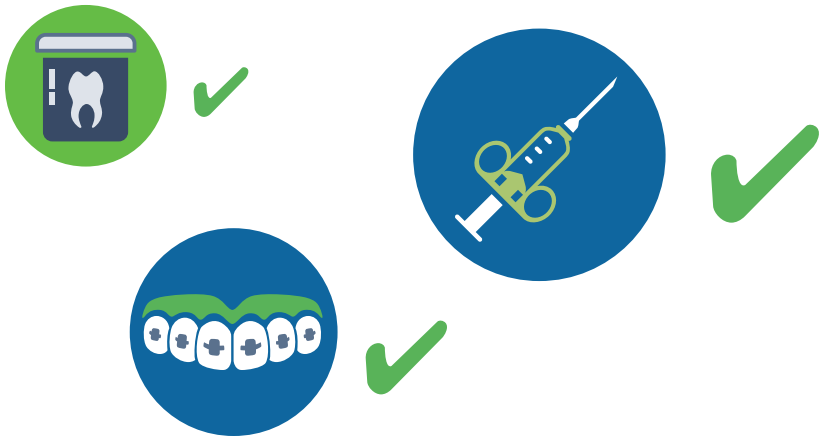
The topic of informed consent is a common thread in the articles that appear in Dispatch. With the current issue of Dispatch, PEAK revisits this important subject and offers members the following expanded article – Informed Consent: From Material Risks to Material Information, by Brian Gover and Stephen Aylward, lawyers with the firm Stockwoods LLP.

The article examines the subject of informed consent in a comprehensive fashion and provides an in-depth discussion, with reference to legislation, legal cases and disciplinary decisions, about several key issues, including:

- material information for informed consent
- the importance of patient centricity
- capacity to consent
- delegated discussions and the use of consent forms
- causation as a limit on civil liability
- disclosure of personal facts by health professionals

The article concludes that both the courts and regulators require health professionals to be skilled in delivering treatment, and also in consulting with patients and ensuring that they are empowered to make fully informed decisions about their health. This imperative requires dentists to exercise sound judgment in clinical situations that can be difficult.

...a dentist's failure to obtain informed consent from a patient may result in a finding of professional misconduct.



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PEAK

Informed Consent: From Material Risks to Material Information

Brian Gover and Stephen Aylward

The authors are indebted to the Honourable Justice Eleanore Cronk for her article, "Informed Consent in 2001: A Complex Legal and Ethical Issue Viewed in Current Legal Climate" Dispatch. June 2001, suppl.

Royal College of
Dental Surgeons of Ontario

Ensuring Continued Trust

Supplement to February/March 2016 issue of Dispatch magazine

Brian Gover was called to the Bar in 1983 and began his career with the Ontario Ministry of the Attorney General, Crown Law Office - Criminal, where his practice included representing the Crown in the Ontario Court of Appeal and the Supreme Court of Canada, and conducting special prosecutions. Between 1991 and 1993, Brian was Executive Legal Officer to what is now known as the Superior Court of Justice. Since 1994, he has been a partner in Stockwoods LLP conducting a varied litigation practice that spans civil and criminal litigation, as well as regulatory and administrative law. Brian leads the firm's tribunal advisory practice and is counsel to the discipline and fitness to practice committees at numerous colleges. Brian has been an adjunct professor of law at Western University (1998-2002) and Osgoode Hall Law School (2009-2012) and an instructor at the Trial Practice course at Osgoode Hall Law School (2004-2008). He is a fellow of both the American College of Trial Lawyers and the International Academy of Trial Lawyers.

Stephen Aylward joined Stockwoods LLP as an associate in 2014. Prior to joining Stockwoods, Stephen served as a law clerk to the Honourable Justice Thomas Cromwell at the Supreme Court of Canada. He holds a J.D. from the University of Toronto Faculty of Law and a law degree from the University of Oxford, where he studied as a Rhodes Scholar. He also holds a B.A. (Hons.) in Philosophy from McGill University, where he held a Greville-Smith Scholarship. He is a member of The Advocates Society, the Ontario Bar Association, and the Canadian Bar Association. His writing on administrative monetary penalties has been cited by the Supreme Court of Canada.

Informed Consent: From Material Risks to Material Information

There has been a decisive break with the "health professional knows best" attitude that dominated most of the last century. Dentists and other health care professionals today live in a world where priority is given to the autonomy of the patient. What might be called the "informational asymmetry" between the expert health care professional and the lay patient poses a challenge for the full exercise of a patient's autonomy. The legal and ethical duty of a dentist to obtain informed consent levels the playing field by ensuring that the patient understands the most important aspects of treatment. The mere fact that a patient sits in the patient's chair is a far cry from informed consent in today's legal environment.

This article will discuss some of the key principles that emerge from the legislation, cases, and disciplinary decisions around informed consent. Many of the cases involve other types of health professionals, particularly doctors, but the same principles are applicable to dentists.

While the law of informed consent is full of intricacies and challenges, some of the key points about informed consent discussed in this article include:

1. Informed consent is a process: It involves dialogue between dentist and patient. Consent should be obtained before the commencement of treatment and renewed throughout the course of treatment.

2. "Informed" includes all material information, not just material risks: As case law on informed consent has developed, courts have expanded the scope of what a patient is entitled to know. The courts take a patient-centric view of what a reasonable patient would like to know, including alternative procedures, risks, and side effects.

3. Understanding and appreciation: A patient has the capacity to consent when he or she understands the information relevant to making a decision about the treatment and appreciates the reasonably foreseeable consequences of a decision or lack of a decision. Particular care must be had with young children and with adult patients who have cognitive disability.

4. Encourage questions: Questioning by patients allows a doctor to appreciate what is important for the patient's specific circumstances and lifestyle. Questioning by a patient is often the best evidence of the patient's understanding.

5. Delegation: A dentist may delegate discussions about informed consent but must be very careful in doing so. The dentist remains responsible for any failure in obtaining informed consent and must ensure that the delegate is competent.

6. Consent forms: Consent forms can be an important tool to allow patients time to reflect on a proposed course of treatment. But a signature on a consent form is only one piece of the puzzle. A signed consent form is evidence of dialogue about informed consent but is not the consent itself.

7. Lists of risks and side effects: These lists can be useful tools in ensuring that a patient is aware of the material and serious risks and side effects of a treatment. Caution must be used with these lists, as it is easy to omit an item and they must be updated in light of new research.

8. Detailed charting and documentation: Detailed, contemporaneous notes of discussions with a patient about consent are the best evidence that meaningful dialogue occurred. The maxim that "if it wasn't charted, it didn't happen" is a slight exaggeration but it remains an important rule of thumb.

9. Standardized practice: Courts are prepared to accept evidence of a dentist's invariable practice regarding discussions of consent as evidence that a discussion occurred in a particular context. Sticking to a standardized practice, while remaining responsive to the particular concerns of an individual patient, is essential.

INFORMED CONSENT IS A LEGAL AND ETHICAL DUTY OF DENTISTS

Outside of emergency situations, where a patient's consent to treatment may be presumed, informed consent is required before a health care practitioner can initiate any treatment in Ontario.

Informed consent is both a legal and an ethical duty for dentists. Dentists owe a duty of care to their patients to ensure that they provide informed consent to a treatment. If the patient is not properly informed of the nature of the treatment, its risks, and alternative procedures, a dentist may face civil liability in a case where the procedure leads to complications.

Informed consent is also an ethical duty for dentists. Failure to obtain consent for a procedure for which consent is required is professional misconduct under s. 2(7) of the *Professional Misconduct Regulation*, O. Reg. 853/93 under the *Dentistry Act, 1991*, S.O. 1991, c. 24. Failure to obtain consent could result in a finding of professional misconduct.

As a practical matter, a substantial number of patient complaints about lack of informed consent arise in the context of billing disputes. Ensuring that the patient is fully informed about the cost of dental treatment ahead of time can place a treatment in financial context and thus reinforce the patient's understanding of how serious it is.

WHAT IS INFORMED CONSENT?

The modern law of informed consent in the health care context can be traced to the Supreme Court of Canada's 1980 decisions in *Hopp v Lepp* and *Reibl v Hughes*. In *Hopp v Lepp*, the court unanimously recognized the need for consent by a patient to treatment to be properly informed:

> [the doctrine of "informed consent"] reflects the fact that although there is, generally, prior consent by a patient to proposed surgery or therapy, this does not immunize a surgeon or physician from liability for battery or for negligence if he has failed in a duty to disclose risks of the surgery or treatment, known or which should be known to him, and which are unknown to the patient. The underlying principle is the right of a patient to decide what, if anything, should be done with his body: see *Parmley v. Parmley and Yule* at pp. 645-46. (I leave aside any question of emergency or of mental incompetency and, also, situations where the operation or treatment performed or given is different from that to which the patient consented.) It follows, therefore, that a patient's consent, whether to surgery or to therapy, will give protection to his surgeon or physician only if the patient has been sufficiently informed to enable him to make a choice whether or not to submit to the surgery or therapy. The issue of informed consent is at bottom a question whether there is a duty of disclosure, a duty by the surgeon or physician to provide information and, if so, the extent or scope of the duty.

The court further elaborated on the nature of the duty of a health professional to ensure that a patient was sufficiently informed as follows:

> [the health professional] should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation.

The health professional's duty to answer questions and disclose risks is a duty to do these things in the manner of a reasonable practitioner. In other words, if a dentist answers a question incorrectly or is unaware of a material risk, it is no defence to rely on that ignorance if a reasonably competent dentist would be aware of these matters. The law of informed consent thus imports a duty of continuing education on dentists and other health practitioners. A patient is entitled to reasonable answers to his or her questions. Moreover, a dentist should pay particular heed to what these questions say about a patient's circumstances or interests.

MATERIAL RISKS MUST BE DISCLOSED

One of the more common issues that arises with respect to informed consent relates to the non-disclosure of risks which then materialize. A patient who was not warned of the existence of these risks may justifiably feel wronged when they result from an operation.

On the other hand, there is a danger in dentists focusing exclusively on the risks of a treatment in discussions with a patient. The patient may lack the expertise to place these matters in context and may be scared away from a beneficial treatment in the face of a long list of risks and side effects. Indeed, the Ontario Court of Appeal recognized in 1981 in *Videto v Kennedy* that the emotional condition of the patient and his or her reluctance to undergo the recommended treatment may in some cases justify the dentist in withholding or generalizing information as to which he or she would otherwise be required to be more specific. Withholding information in these circumstances should only be done after careful consideration and documentation of the basis for the decision.

The balance struck by the courts has been that a dentist must disclose material risks and special risks. The materiality of a risk is measured both by the gravity of the outcome and the frequency of its occurrence. A relatively minor risk should be disclosed if there is a substantial likelihood of it occurring. Not every remote possibility needs to be disclosed, but where the consequences are serious, such as permanent disability or death, the risk should be disclosed even where the probability of occurrence is low.

The discussion of risks should focus on the specific treatment being proposed. In the case of surgery, it is not necessary to disclose all the attendant risks of surgery in general, such as those of anesthetic or of infection, subject to the requirement that particularly grave risks should be disclosed.

FROM MATERIAL RISKS TO MATERIAL INFORMATION

The earlier cases such as *Reibl v Hughes* placed heavy emphasis on the importance of health care practitioners disclosing risks and the consequences of non-disclosure of such risks. Courts rapidly expanded the notion of informed consent to go beyond the disclosure of risks and the answering of specific questions to a broader duty to provide all material information to a patient relevant to a decision about treatment.

This broader concept of informed consent is reflected in the meaning of informed consent that has been set out by statute in Ontario. Under s. 11 of the *Health Care Consent Act*, 1996, SO 1996, c 2, Sch A, consent is informed where a dentist informs of the patient of:

- the nature of the treatment
- the expected benefits of the treatment
- the material risks of the treatment
- the material side effects of the treatment
- alternative courses of action
- the likely consequences of not having the treatment
- the answers to the patient's questions about the treatment.

Besides the disclosure of material risks, discussion of alternative treatments is one of the most important aspects of informed consent. Allowing the patient to understand the options, including the consequences of inaction, is essential for the patient to make an informed decision about the treatment. Ideally, a dentist would discuss the key features of the alternative treatment(s), including material risks and benefits.

It is only necessary to discuss true alternatives to the proposed course of treatment. Thus, in one case, a surgeon failed to discuss a non-surgical means of removing kidney stones. However, the patient had specifically expressed a desire to avoid recurrence of the pain and this result would not be achieved by the non-surgical option. The court held that there was no need for the doctor to disclose an alternative treatment that was not responsive to the patient's desires. That said, dentists may wish to err on the side of caution in discussing alternative treatments to avoid the risk that a court will find after the fact that a near alternative should have been disclosed.

Similarly, where a health care professional prefers one form of treatment to another that is more commonly accepted, he or she should disclose that fact and explain his or her position on the advantages of the preferred treatment. It is not acceptable to simply go ahead with the preferred treatment without informing the patient of the issue.

At a more extreme level, a health care practitioner must inform a patient where a proposed treatment is untested, experimental, or faces skepticism from the broader community of practitioners.

INFORMED CONSENT IS PATIENT-CENTRIC

As the Supreme Court observed in *Reibl v Hughes*:

> The patient may have expressed certain concerns to the doctor and the latter is obliged to meet them in a reasonable way. What the doctor knows or should know that the particular patient deems relevant to a decision whether to undergo prescribed treatment goes equally to his duty of disclosure as do the material risks recognized as a matter of required medical knowledge.

In this and other passages, the Court recognized that informed consent is to be assessed from the perspective of the patient. In other words, the question is not what a reasonable health care professional would disclose, but what a reasonable person in the patient's position would want to know about the procedure. One consequence of this is that a court will look beyond the professional standards of the dentistry profession when determining what information should have been disclosed to a patient. This includes documents such as the RCDSO's *Practice Advisory: Informed Consent Issues Including Communication with Minors and with Other Patients Who May Be Incapable of Providing Consent* (August 2007). Such standards are an important factor to be taken into consideration but they are not determinative of civil liability.

Another implication of the patient-centric approach to informed consent is that the health professional need not even be aware of personal circumstances that would cause a patient to forego or postpone treatment for a patient to recover damages. The Ontario Court of Appeal made this point in *Lue v St. Michael's Hospital*. The patient was left with permanent paralysis in his right hand, arm, and leg following a surgery to remove a brain aneurysm. The patient maintained that he was not informed of the risk of such paralysis and that if he had been informed, he would have delayed the surgery for several months, by which point he would have become eligible for long-term disability insurance benefits. The trial judge rejected the patient's claim on the basis that the doctor had not been informed of these economic circumstances but the Court of Appeal disagreed with the trial judge on this point. When a doctor fails to disclose a material risk and the patient, acting reasonably, would have chosen a different course of action had the risk been disclosed, the patient is entitled to damages regardless of whether the doctor was aware of the circumstances. Ultimately, however, the Court of Appeal denied the patient's claim because he did not prove that he would in fact have postponed the surgery. Liability for a breach of the duty to warn by a dentist in a situation where a patient could prove that he or she would have taken a different course of action (whether

postponing the treatment or foregoing it altogether) would be calculated so as to compensate the patient for any loss or injury that would not have arisen if he or she had been properly warned.

The patient-centric nature of informed consent means that the courts will consider the specific circumstances of a given patient. This is because certain risks will be more salient for some patients than others. Younger patients or patients whose appearance is important for their profession may be more concerned about scarring or other disfiguration. A sole parent with several dependents may be particularly averse to any risk of serious disability. The importance of timing may also play a role, as in the case of *Reibl v Hughes* itself, where the patient would have been entitled to a lifetime pension if the surgery were carried out 18 months later.

The shift to a patient-centric understanding of informed consent does not mean that the "patient is always right." Dentists must respect a patient's bodily autonomy but this does not give patients a right to receive medically unnecessary treatment. Where a dentist believes there is no reason for a requested treatment, he or she may justifiably decline to provide it.

CAPACITY TO CONSENT

One of the most difficult areas relating to informed consent occurs with respect to questions of capacity. Under s. 4(1) of the *Health Care Consent Act*, a patient has the capacity to consent when he or she understands the information relevant to making a decision about the treatment and appreciates the reasonably foreseeable consequences of a decision or lack of a decision. The ability to "understand" and "appreciate" requires certain cognitive functions, including memory, reasoning and decision-making ability. In most cases, a dentist may presume that a patient has the capacity to consent. Two special cases that call for attention are minors and adults with cognitive disabilities.

In Ontario, there is no fixed age of capacity to consent for medical treatment. Whether or not a minor is able to consent turns on a case-by-case determination by the health care practitioner involved. The RCDSO's *Practice Advisory* on informed consent recommends a presumption that minors under the age of 12 are unable to consent, while minors above the age of 16 are able to consent. The more difficult cases will involve minors between 12 and 16. In these cases, a dentist should hold a discussion with the patient about the proposed treatment and elicit questions from the patient that might assist the dentist in gauging the patient's understanding and appreciation of the treatment. Careful, contemporaneous notes should always be made of the content of these discussions and of their outcome. If a minor lacks the capacity to consent, a parent or guardian must consent to the treatment on his or her behalf.

In cases involving minors, it is essential to draw a clear distinction between the customer (usually a parent or guardian who is paying for the services) and the patient (the minor). A dentist's obligations with respect to his or her patients are not changed simply because a third party is paying the bills. In such a scenario, the dentist must preserve patient confidentiality unless and until the patient consents to information being shared with a parent or guardian.

Where there is reason to doubt the capacity of an adult patient to consent to a treatment, a dentist should discuss the proposed treatment with the patient and attempt to gauge the patient's appreciation and understanding of the treatment. If the dentist is of the view that the patient lacks the capacity to consent, the dentist should inform the patient of this and of the patient's right to appeal this decision to the Consent and Capacity Board. More information on the issue of capacity to consent can be found in the RCDSO's *Practice Advisory*.

Another special case involves language barriers. Where the dentist and patient do not speak the same language, the dentist must ensure that a translator is involved so that the patient is fully informed. A family member or friend may be able to play this role, but dentists should be sensitive to any pressure being placed on the patient by other family members.

Regardless of whether there are any communication difficulties, dentists should resist the urge to use jargon and should try to speak to patients in plain English. As one court put it "the language used by the doctor should be such that the patient can easily understand it. The utilization of medical terms replete with Latin words does not satisfy this requirement." In one case, a health professional disclosed the risk of a stroke to his patient but the patient did not understand what a stroke was or that it was a serious matter. The court decided that greater explanation was needed of the causes and effects of such a serious risk.

While assessments of a patient's understanding may be challenging in a clinical setting, there are objective steps that a dentist can take to increase the likelihood that he or she will be understood by the patient. The trial judge

in *Lue v St. Michael's Hospital* set out a number of objective criteria for courts to consider when determining whether a patient properly understood a proposed treatment and most of these factors can be addressed by proper procedures, as set out by Eleanor Cronk in her 2001 article on informed consent.

1. Whether the patient asked any questions. A failure to ask appropriate questions may indicate the patient is overwhelmed and uncomprehending. As a corollary, the comments or questions that the patient does raise may also reveal comprehension of the material risks.

2. Whether diagrams or other visual aids are relevant. Depending on the intellectual abilities of the patient, pictorial depictions may be part of the process.

3. Whether the patient can restate what the physician has communicated. At some point after the disclosure, can the patient describe, in his or her own terms, the procedure and risks which are about to unfold.

4. Whether the patient has asked for a second opinion. Patients are understandably reluctant to be perceived as doubting the advice of the doctor by suggesting a second opinion. But when the "organ of our humanity" is involved, the doctor should consider raising it as a possibility and explain to the patient how that course of action could be implemented.

5. Whether any information is put in writing. For example, does the patient have access to brochures which describe the generic condition with usual questions and answers? Did the dentist write a note or letter to the patient? Did the dentist make a note in the patient's chart? Is there a protocol in writing for the physician to follow and was it followed?

6. Whether the time spent with the patient is realistic in terms of enabling the patient to comprehend the nature of the treatment and to have this message reinforced? Is the patient afforded an opportunity to ask questions?

7. Whether the patient is dependent on family members for assistance in decision-making or whether the treatment, or lack thereof could result in impaired cognitive abilities. In either case, involvement of the family is not a courtesy, it is a necessity. If others are involved, whether their recollection of events coincides with the doctor's will be an important consideration.

8. Whether the patient or family express spontaneous surprise when the event, described in advance as a material risk, unfolds. A court may look to this as circumstantial evidence of the disclosure that was made beforehand.

WHO PROVIDES THE INFORMATION?

It has been settled in the case law for some time that a health professional does not personally need to inform the patient of all material facts relating to a proposed treatment. These discussions can be delegated to a competent colleague, such as a dental hygienist. These discussions can also be carried out by multiple practitioners, so that different aspects of a treatment are discussed by different members of a team or practice. In some cases, courts have even accepted that information provided by a health professional who was a friend of the patient was sufficient. The cases recognize that the main consideration is that the patient actually be informed.

The availability of a wealth of medical information on the internet raises an interesting question for the law of informed consent, namely, what weight should be given to the fact that a patient has conducted his or her own research online? Even if a health professional neglects entirely to inform the patient of the relevant information, the patient might in fact be equally or even better informed than patients with more diligent dentists by virtue of internet research. This issue was considered by the Saskatchewan Court of Appeal in the case of *Prevost v Ali.* The court held that the significance of information from a non-medical source would depend on the circumstances of a given case, but held on the facts of that case that the information obtained by the plaintiff from the internet was not sufficient to constitute informed consent. The patient had a grade 8 education and there was no evidence before the court as to the quality of the internet research he had conducted.

CONSENT FORMS

There are a number of tools available to assist dentists in ensuring that patients are well-informed and empowered to make decisions about their treatment.

Consent forms present a serious danger in that they can create a false sense of security. A patient's signature on a consent form is only as good as the information that the patient actually receives in the course of the consultation with the dentists. As a leading text, *The Canadian Law of Consent to Treatment,* 3rd ed (Markham: LexisNexis, 2003) puts it:

> ...consent is a 'process' and not a form. The fact that a person has signed a consent form does not necessarily mean that consent has been given, that it was informed, that the consent was valid, or that the procedure performed was the procedure for which consent was obtained. In considering whether there has been a valid consent, a court is required to examine all relevant circumstances, not just the written form.

This being said, consent forms can play an important role by focusing the patient's attention on the importance of consent. The ideal consent form would be tailored to the specific procedure at issue and would address the gravity of the procedure, the material risks, side effects, alternative treatments, and the consequences of inaction. Any list of risks should not minimize the likelihood of such risks occurring.

CAUSATION AS A LIMIT ON CIVIL LIABILITY

Where a patient can show that his or her dentist failed to provide sufficient information about some form of treatment, the next question for a court is whether the patient is entitled to any damages. The benchmark for this analysis is what a reasonable person in the patient's position would have done, had he or she been properly informed of the material facts.

Note that it is not enough for the patient to say that he or she had a subjective fear or aversion to a particular risk or side effect of the treatment. Rather, the patient must show that a *reasonable* person would have decided on a different course of treatment had he or she been properly informed about the treatment. The advantage of this approach is that a patient is not allowed to rely on idiosyncratic fears after the fact to suggest what would have occurred. Discussions around informed consent must center on what a reasonable person in the patient's position would base a decision about the treatment on. This rule – first formulated by the Supreme Court in *Reibl v Hughes* and was later confirmed by it in *Arndt v Smith* – provides some measure of protection to dentists and other health professionals.

It is important to bear in mind the situation of the individual patient when evaluating what is reasonable in a given case. For example, the loss of an eye as a result of the non-disclosure of this outcome as a material risk might bring about the loss of a job for which good eyesight is essential. The fact that the patient works in a job where eyesight is important gives particular weight to the non-disclosure of this risk. The court in *Reibl v Hughes* emphasized that a patient's particular concerns must be reasonably based. A plaintiff's idiosyncratic fears or desires will not be allowed to shape the contours of a dentist's liability.

There must be a causal connection between the failure of the dentist to disclose material information and the harm suffered by the plaintiff and the plaintiff must be able to prove this causal link. This requires that the plaintiff must be able to show that a reasonable person in his or her position would have acted differently and so avoided the loss. Timing will be significant in some cases, such as *Reibl v Hughes* itself, where a delay of 18 months would have solidified the plaintiff's financial outlook. However, the plaintiff must do more than simply show that a delay in the treatment would have occurred if proper disclosure had been made. This is particularly so where the treatment itself was competently performed but complications arose nonetheless. In a number of decisions, including by the Ontario Court of Appeal in *Felde v Vein and Laser Medical Centre*, the courts have held that plaintiffs may not rely on an inference that, if the surgery had been postponed, chance would have shown them more favour.

DISCLOSURE OF PERSONAL FACTS BY HEALTH PROFESSIONALS

One interesting application of the causation principle has arisen in the case law with respect to a health care practitioner's duty to disclose matters relating to his or her own health. In *Halkyard Estate v Mathew*, the patient suffered complications from a hysterectomy and died. It emerged that the surgeon suffered from epilepsy, for which he was taking medication. There had been no seizure during the course of the operation and the patient's death was causally unrelated to the surgeon's

epilepsy. The plaintiff claimed that the surgeon had breached his duty of disclosure by failing to disclose the existence of the condition and that, if the matter had been disclosed, the surgery would not have gone ahead. The Alberta Court of Appeal held that a doctor has no duty of disclosure with respect to his or her own health issues where these are unrelated to harm suffered by a patient.

In another case involving disclosure by a health care practitioner, it was decided that a health professional was under no obligation to disclose his lack of experience where he was qualified to render the treatment in question. Obviously, a patient might be nervous to learn that a dentist had never carried out a procedure before but all dentists have to start somewhere. An alternative approach to this question that has been taken by some courts is to say that a reasonable person would consent to a treatment by a properly qualified health professional regardless of their level of experience and so no losses flow from a failure to disclose a lack of experience.

SUMMARY

The paradigm shift initiated by the Supreme Court in *Hopp v Lepp* and *Reibl v Hughes* 35 years ago has had a profound impact on the relationship between dentists and their patients. The patient-centric approach taken by courts and regulators requires health professionals to be skilled not only at delivering treatment but also at consulting with patients and ensuring that they are empowered to make fully informed decisions about their health. This imperative requires dentists to exercise sound judgment in what can be difficult clinical settings.

While the boundaries of what must be communicated to patients continue to evolve, patients themselves are able to access vast quantities of health care information through digital means that could not have been imagined in 1980. As the nature of the dentist-patient relationship and the legal concept of informed consent continue to evolve, the foundation of dentist-patient dialogue will endure as a touchstone of sound practice.

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