Informed Consent - What Your Patient Doesn’t Know Can Hurt You

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Most practitioners are surprised to learn that they can be held liable to a patient for an unintended surgical complication even if the dentist’s surgical technique was well within the standard of care. How can that be? The answer is four simple words: “lack of informed consent.”

All too frequently in our litigious society patients claim that they would not have undergone a particular treatment if the doctor had advised them of the risks of that procedure. For example, although practitioners know that the surgical removal of a lower third molar can result in nerve injury or a fractured mandible, I suspect that few patients are aware of those risks. Without an awareness of, and appreciation for, the magnitude of the risks in this unique situation, a patient cannot give informed consent to undergo a procedure.

An Educational Process

Informed consent is more than a piece of paper that the patient signs advising them of the risks of a particular procedure. Rather, informed consent is an educational process—it is the process by which the practitioner informs and educates his or her patient of the risks, benefits, and alternatives to the proposed treatment, and then obtains the patient’s consent to provide that treatment. The goal of a good, effective informed consent process is to provide education tailored to the patient’s unique clinical presentation.

The educational process should include a discussion with the patient regarding the:

- intended outcome and benefits of the proposed treatment,
- the potential alternatives to the proposed treatment (no treatment is always an option),
- how the proposed treatment compares to the alternatives, and
- the material risks and potential complications of the proposed treatment.

The educational process may be brief or protracted, or anywhere in between, depending upon the clinical presentation and the treatment at issue.

For example, the consent process for a simple two-surface restoration will be much less detailed than the consent process for the surgical extraction of a tooth to be followed by bone augmentation and implant placement. Again, patient education is the goal.

Generally speaking, there is no requirement that the patient be warned about risks and potential complications that are exceedingly rare. Rather, a discussion about the material risks and potential complications of the procedure as generally recognized by the dental community should suffice.

Written Informed Consent

Although in some states there is no requirement that the patient’s consent be in writing in order to be legally effective, obtaining the consent in writing as part of the educational process is highly recommended. The consent form should be completely filled out before the patient signs it, and no alterations should be made to the form once it has been signed. It is also advisable to note in the patient’s chart that the risks, benefits, and alternatives were discussed with the patient prior to the procedure. See page 3 for additional tips on written consent.

A lack of informed consent case is the “darling” of plaintiff’s attorneys. Failure to obtain the patient’s informed consent exposes the dentist to legal liability for a complication even if the surgical technique was top-notch. Indeed, what your patient doesn’t know can hurt you.
The patient presented to our insured for placement of an implant at #30. The patient signed an informed consent form stating numbness of the lip, tongue, chin, cheek, or teeth may occur. After obtaining a panorex and radiograph, our insured placed the implant. A post-operative radiograph showed that the implant was near the inferior alveolar nerve. This finding was shared with the patient. Two days later the patient returned complaining of paresthesia. The patient was told that the numbness could be caused by swelling putting pressure on the nerve. Our insured advised the patient that it may take 2-6 months to regain sensation, and that there was a chance the numbness could be permanent. A CT scan was ordered which showed the implant impinging on the nerve. Our insured subsequently removed the implant.

Our insured advised the patient that a referral could be made to an OMS for the possible repair of the damaged nerve. The patient did not return to our insured and decided to wait and see if sensation returned. One month later, she saw an OMS who diagnosed her with traumatic neuropathy of the IAN following the placement of an implant. The OMS believed that the injury was likely permanent and could not be repaired through surgical measures.

The patient retained an attorney and filed a lawsuit against our insured. The plaintiff alleged that our insured placed an implant that was 2 mm longer than the bone above the inferior alveolar canal and caused a compression nerve injury. As the case progressed, the evidence suggested that our insured may have mistaken the inferior border of the inferior alveolar canal for the superior border. Our insured was criticized for failing to obtain appropriate pre-operative imaging which would have demonstrated the location of the IAN. A dental radiologist was asked to provide expert review for the defense. However, the dental radiologist was unable to defend the length of the implant used by our insured. Given that this was a case of likely liability, discovery focused on evaluating the extent of the plaintiff’s damages and resolving the matter early in the lawsuit process. With the insured’s consent, Fortress was able to negotiate a reasonable settlement early in the case and without further litigation.

What changes in procedures should I notify Fortress of and why does the Company need to know?

When an applicant applies for insurance, the terms of coverage are based on the information provided during the initial application process, and then re-evaluated during the renewal process. While this process is a good means of updating practice data, it is not typically an annual event. Therefore, it is important that you keep your agent up-to-date on significant changes that impact your practice throughout your career. Depending on the change, it may or may not impact your insurance coverage and premium. For example, if you relocate to a lower rated territory, your premium may decrease. On the other hand, if you incorporate more complex procedures during the course of your career, your premiums may increase.

Our experience has shown that dental claims associated with these procedures result in higher losses:

- administering or treating patients under moderate or deep sedation,
- performing surgical placement of implants, and
- performing extraction of impacted teeth.

If you incorporate the above procedures into your practice, or anticipate other changes to your practice, we encourage you to discuss the potential impact, if any, on your professional liability policy with your agent.
As the lead article mentions, written informed consent is good risk management and should be incorporated as part of the patient education process. In addition to the elements cited in the lead article to address in your informed consent discussion with the patient, consider these key elements for written documentation of the informed consent process:

<table>
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<tr>
<th>1</th>
<th>Document in the patient’s chart that a discussion occurred between the dentist and the patient about the patient’s diagnosis, the proposed treatment, the treatment alternatives, the benefits, the material risks (i.e. not extremely rare and uncommon risks), the potential complications of the proposed treatment and the risks of refusing the proposed treatment. If applicable, document the discussion about anesthesia, pre-procedure, and post-procedure instructions in the chart.</th>
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<td>2</td>
<td>The consent form is signed by both the patient and the doctor and, preferably, by a witness.</td>
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<td>3</td>
<td>The consent form itself should be specific to the procedure and should include informed consent for the type of anesthesia to be used (unless a separate anesthesia consent form is used).</td>
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<td>4</td>
<td>The patient must sign the form after the informed consent discussion and before the procedure and any sedations or narcotics are administered. The chart note about the discussion of informed consent should have an entry that states that the consent form was signed after the discussion of informed consent.</td>
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<td>5</td>
<td>Only natural parents, adoptive parents, and legal guardians can give consent to treatment for a minor.</td>
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<td>6</td>
<td>Informed consent must be obtained by the doctor who will actually be performing the procedure. Staff may not obtain informed consent.</td>
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**Informed Consent Forms**

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Login to [www.dds4dds.com](http://www.dds4dds.com) and click the “Fortress Resource Center” link on the left side of the page to access a library of informed consent forms and patient education documents. Download and customize each form for your practice’s needs.

Available forms/documents include:

- Consent for Dental Treatment
- Consent for Extraction of Teeth
- Consent for Dental Implant Surgery
- Non-compliance Letter
- Informed Refusal of Treatment Letter
- Notice of Privacy Practices
The live Fortress three-hour seminar, Risk Management Strategies to Reduce Dental Liability, discusses several risk management scenarios including abandonment, supervised neglect, informed consent and patient selection. For more information about the live seminars, visit our website at www.dds4dds.com or email RM@fortressins.com.

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