



Informed consent as an ethical principle

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“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”

So said Justice Benjamin Cardozo in 1914, translating into law a fundamental ethical principle: the duty to respect a patient’s autonomy.¹ But how much information has to be given to a patient to ensure that the patient’s right of self-determination has been respected?

Many doctors confuse **valid** consent (sufficient to defeat an accusation of assault or battery, that is, an “unlawful touching”), and **informed** consent (sufficient to defeat an accusation of negligent non-disclosure).

The tests for valid consent are:

1. Has the patient been given information about the nature and purpose of the treatment?
2. Is the patient able to understand that information?
3. Is the patient’s consent freely given? Is there any sign of coercion from another person (spouse, parent, etc).

Informed consent requires one further element: provision of information about risks, benefits, alternatives, and so on.

The High Court of Australia² has affirmed that the doctor’s duty of care is one duty with three components: diagnosis, treatment and provision of information. Whether a doctor breached duty of care in diagnosis and treatment is a matter for expert

medical advice. Judges and juries do not have the knowledge to make that assessment. However, they can stand in the patient’s shoes and decide whether the information provided to a patient was “enough”.

Two tests apply in deciding which information should be given to a patient:

1. Reasonable patient – the “objective test”

This is the information you should provide to every patient about a proposed procedure. A patient education pamphlet would meet this test if:

- the pamphlet is in a language the patient can read
- the patient can understand the information
- you go through it with the patient and explain the content.

2. Particular patient – the “Subjective Test”

In addition to the information you provide to every patient, you need also to show that you have turned your mind to this particular patient. This is a two-step process, as follows.

a) The Reasonable Doctor

Is there other information any reasonable doctor would add, knowing of the circumstances of this particular patient?

b) The Individual Patient

Is there other information the patient wants, having been given the opportunity to seek further information? Ask open questions such as “Is there anything you don’t understand?” or



Dr Paul Nisselle

“Is there anything else you’d like to know?” or “Do you have any questions?”

You must document the discussions you have with patients. The records do not have to be voluminous. Single words with a “✓” beside them are enough to show you considered that risk

and discussed it. If you use a pamphlet, such as one supplied by your College, you could write, “College info sheet ✓ Discussed ✓” as evidence that you addressed the objective reasonable-patient test. The final notation might be “N.O.Q.” (shorthand for “no other questions”), which would be reasonable proof that you checked whether the patient wanted further information.

Avant still has a few cases due to pregnancy after tubal sterilisation. Where there has been no surgical error, the assertion is usually that no warning was given of the remote risk of pregnancy. “Warned re risk of pregnancy” written in the notes will usually rebut such a claim.

The key is to provide information structured around the reasonable patient, reasonable doctor and individual patient triad, and to record the information provided.

It’s unthinkable to take a patient’s blood pressure and not record it in the notes. It’s equally unthinkable to have a discussion with a patient without recording a summary of that discussion in the notes. ©

1. Schloendorff v. The Society of New York Hospital, 211 N.Y. 125 (at 129-130), 105 N.E. 92, 93 (1914).
2. Rogers v Whitaker (1992) 175 CLR 479..



Referring your patients to an internet site is not enough to establish informed consent and could be counterproductive to your risk management.

Dr Calvin Miller
Director
Mi-tec Medical Publishing

In recent years, I have received queries from dentists and oral and maxillofacial surgeons who want to put patient education online so their patients can access it on the internet. Their intentions are:

- the dentist can save time because patients will access the information in their time on their own computers
- after accessing the online information, the patients can ask questions at subsequent appointments
- online patient education appears to assist the informed-consent process and the dentist's risk management.

Referring a patient to a website would appear to be helpful, and yes, the internet has become a popular source of information for health consumers. However, while the web can act as a repository of information, that does not imply it is assisting the informed-consent process.

Consider these real-world problems.

- The patient is too embarrassed to admit he does not have a computer or does not know how to use one.
- The patient misplaces the web address that the dentist gave him.
- The server is down or some other technical problem prevents downloading of the patient information.
- Even if the patient successfully downloads the treatment information, that does not imply the patient understands the information in isolation of the dentist. That is, the dentist was not involved in the process of communication and explaining the treatment to the patient.
- A black-and-white printout of a colour anatomical illustration is typically a poor reproduction, and the illustration

The internet is not a patient education solution

may be crucial to the patient's understanding of the treatment.

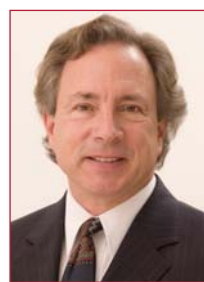
Thus, simply referring the patient to a website could well be setting the stage for one very angry patient in the event of a postoperative complication.

To reduce the risk of litigation, dialogue between the dentist and patient must be established and recorded in the dentist's notes. Patients' access of treatment information on the net does not assure a process of communication.

High-quality hardcopy pamphlets provided by a dentist have the following compelling advantages.

1. The High Court case of *Rogers v Whitaker* (1992). The pamphlets can satisfy *Rogers v Whitaker* considerations by helping to establish a process of communication between the dentist and patient, and assisting the written record. It is the dentist's responsibility to implement a process of communication and to determine material risks, not the patient's. Simply referring a patient to a website would not confirm that process of communication. In fact, it could indicate quite the opposite, with the inference (by a judge, jury or complaints body) being that the dentist was too busy and avoided discussions with the patient.

2. Exclusivity. The patient should receive the information from the dentist. Treatment information should not be distributed independently of the dentist. It is better to think of such pamphlets as "Dentists' information for patients". I often get phone calls from lay people who wish to receive a particular pamphlet and are happy to pay for it, but I decline because the pamphlet must be provided by the dentist in an environment of dialogue and communication.



Dr Calvin Miller

3. Security of print quality. Pre-printed pamphlets present all text and illustrations with the highest print quality. The excellent print quality and full-colour

dental illustrations add credibility and authority. Conversely, it is common for a page from laser printouts to go missing and for toner cartridges or ink-jet cartridges to run out of ink, resulting in illegible pages. A missing page (for example, on complications) would present a problem in the event of a complaint. The case would be difficult to defend.

To play devil's advocate, dentists don't really need the pamphlets at all! Any number of ways could be undertaken to implement and record a process of communication. However, pamphlets do the job quickly, cheaply and easily, making the dentist's task of informed consent much easier and more comprehensive.

In conclusion, a dentist can confirm that a process of communication has been initiated by personally handing to the patient, and discussing, an informative pamphlet that is of the highest standard, both in terms of expertly reviewed content and print quality.

Any substitute of face-to-face discussion and pamphlet quality would not be in the interests of dentists and would contravene the reason for providing patient education: to improve communications between dentists and their patients. ©

This article is derived from a paper that first appeared in O&G Magazine published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists: Weaver T, Robertson A, Miller C. Patient education is best when it's a process. O&G 2007 Spring;9(3):62-3.

Dr Paul Nisselle adds this point:

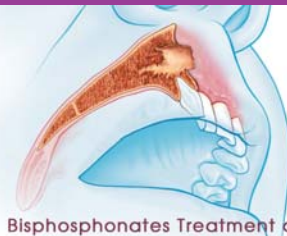
Any standardised communication, whether it be a pamphlet or information on a website, at best can only satisfy the first leg of the *Rogers v Whitaker* standard, that is, the "objective" (reasonable patient) test. And then, only if the patient has the cognitive and linguistic ability to understand the information provided.

Irrespective of how that information has been "transmitted" to the patient, an interactive process with the doctor is required to ensure it has

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Dental Extractions

UPPER TEETH

LOWER TEETH

ASK YOUR DENTIST

When you go to the dentist for a dental procedure, you may be asked to have one or more teeth extracted. This is a common procedure and is usually performed under local anaesthetic. The dentist will explain the reasons for the extraction and the procedure itself. It is important to understand the reasons for the extraction and the procedure itself. It is important to understand the reasons for the extraction and the procedure itself.

Orthodontics

An introduction to the straightening of teeth

TALK TO YOUR DENTIST OR ORTHODONTIST

Your dentist or orthodontist will be able to advise you on the advantages and disadvantages of orthodontic treatment. The general treatment should be discussed with your dentist or orthodontist before treatment begins.

WISDOM TEETH

and what to do about them

ASK YOUR DENTIST

The wisdom teeth are the last to erupt and are often the most difficult to clean. They are often removed because they can cause problems for the other teeth.

Treatment of gum infections

A guide for people with periodontal disease

TALK TO YOUR DENTIST ON PERIODONTITIS

Periodontitis is a serious condition that can lead to the loss of teeth. It is caused by bacteria that infect the gums and the bone around the teeth. It is important to see your dentist as soon as you notice any signs of gum disease.

Root Canal Treatment

A natural tooth is much easier to maintain than an artificial tooth can be.

Talk to your dentist or endodontist

Root canal treatment is a procedure to remove the infected pulp from the root canal of a tooth. It is a common procedure and is usually performed under local anaesthetic.

DENTOALVEOLAR SURGERY

A GUIDE FOR PATIENTS

ASK YOUR SURGEON

Dentoalveolar surgery is a procedure to move a tooth into a better position. It is a common procedure and is usually performed under general anaesthetic.

WISDOM TEETH

AND WHAT TO DO ABOUT THEM

ASK YOUR SURGEON

Wisdom teeth are the last to erupt and are often the most difficult to clean. They are often removed because they can cause problems for the other teeth.

ORTHOGNATHIC SURGERY

A GUIDE FOR PATIENTS

ASK YOUR SURGEON

Orthognathic surgery is a procedure to correct a bite problem. It is a common procedure and is usually performed under general anaesthetic.