Dental Professional Liability

Legal Concepts

Upon completion of this section, you should be able to:

- **Understand the legal concepts that directly relate to clinical practice** such as standard of care, professional liability and negligence.
- **Implement effective risk management procedures and techniques** to address informed consent and informed refusal for all patients.
- **Tailor your practice management techniques to mitigate risks** related to vicarious liability issues.
- **Understand the importance of engaging staff in the risk management process** and provide appropriate staff education.

Please Note

A number of sample risk management forms and letters are available electronically in association with this manual, including written informed consent templates, patient termination letters, records release authorization forms and others. Dentist's Advantage-insured dentists may access these sample documents on the Dentist's Advantage website.

Each PDF sample permits customization: copy and paste the sample text from the PDF template document to a text editing file (MS Word, Apple Pages, etc.); edit text and add your dental practice information where appropriate; save the file to create a blank form for ongoing use. If necessary, customize the text of the form template for specific patient needs. You may wish to include components from various sources if the templates provided do not meet the needs of your practice.

While a number of form templates are available, documents are not available for every dental procedure. We encourage you to create consent forms for those dental procedures you perform frequently. You may wish to use the sample consent forms as an outline and review the manual section on informed consent. Consider consulting your attorney to ensure that your forms comply with state informed consent statutes.

Risk management content and resources are provided for illustrative purposes only. The information is intended to provide only a general overview of the matters discussed and is not intended to establish any standards of care.

The information, examples and suggestions presented in this material have been developed from sources believed to be reliable, but they should not be construed as legal or other professional advice regarding any particular situation.

CNA accepts no responsibility for the accuracy or completeness of this material and recommends the consultation with competent legal counsel and/or other professional advisors before applying this material in any particular factual situations.

Please remember that only the relevant insurance policy can provide the actual terms, coverages, amounts, conditions and exclusions for an insured. All products and services may not be available in all states and may be subject to change without notice. All references to dental claim data refer to CNA claim data.

Any references to non-CNA Web sites are provided solely for convenience, and CNA disclaims any responsibility with respect to such Web sites.

Legal Liability

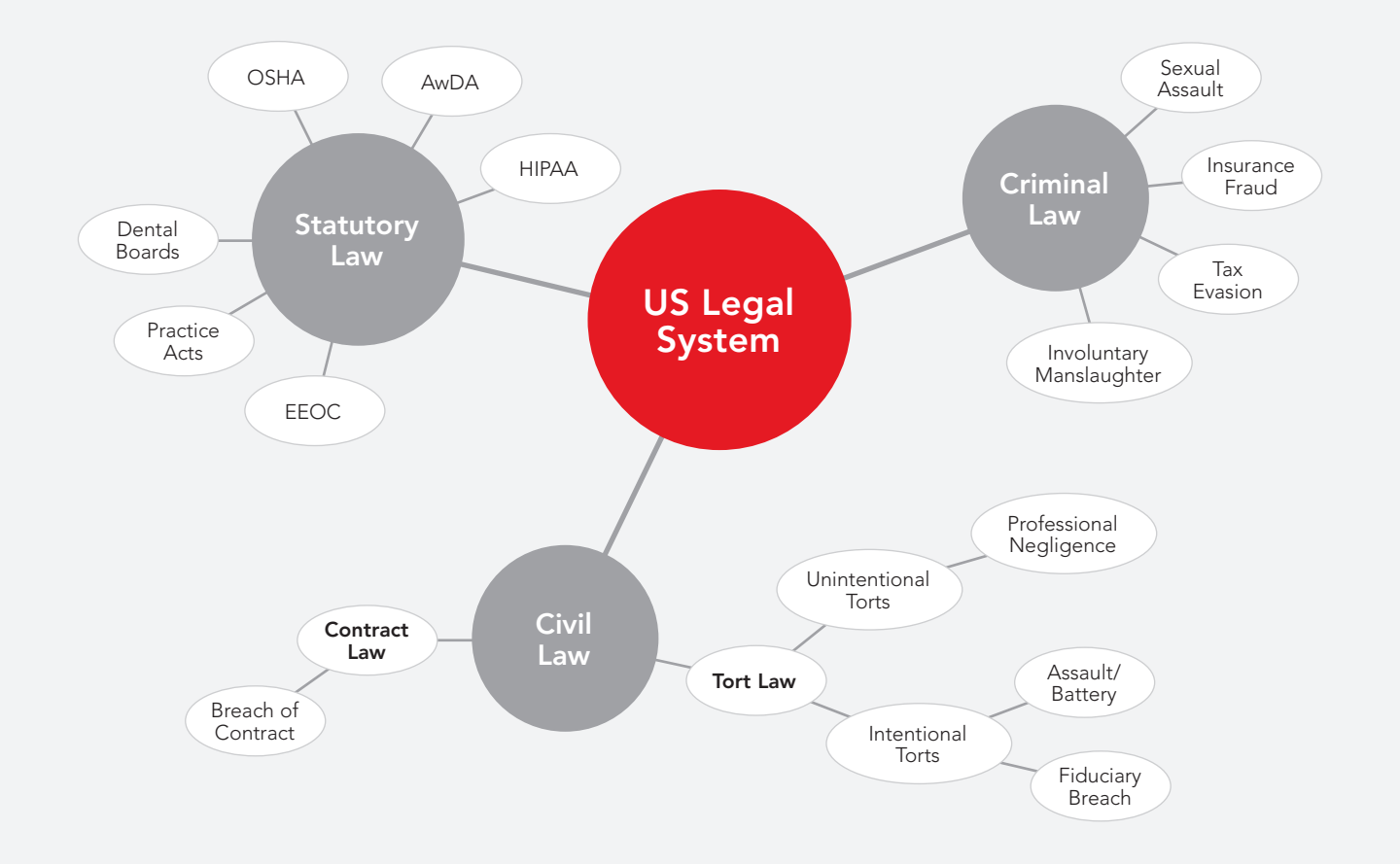
Dentists face a myriad of risk exposures pertaining to legal liability. These exposures arise from various aspects of civil, criminal, and administrative law at both the federal and state levels. The chart below highlights some of the risks dentists must address.

The Americans with Disabilities Act (AwDA)

A complete discussion of the Americans with Disabilities Act is beyond the scope of this manual. Nevertheless, the AwDA is referenced due to the numerous inquiries received regarding application of the law to dentistry. Typical questions involve hearing impaired patients; the presence of service animals; patients with mental health diagnoses; and more.

Signed into law on July 26, 1990 by President George H.W. Bush, AwDA essentially prohibits discrimination against disabled individuals. The law guarantees equal rights related to employment opportunities, access to commercial goods and services and to governmental programs and services. "Disability" is defined by the AwDA as a physical or mental impairment that substantially limits one or more major life activities. It should be noted that the definition also encompasses a person who has a history or record of such impairment, or a person who is perceived by others as having such an impairment. Moreover, the definition may be applied to groups of individuals NOT expressly referenced in the law.

Due to the complexity of various scenarios, dentists should consult an attorney conversant with the AwDA and any similar state laws. In addition, a number of resources are available on the AwDA website. In addition, the U.S. Department of Justice provides a toll-free information line (see http://www.ada.gov) staffed by personnel who can help callers understand the law and how it may apply to specific situations.



Section 1557 of the Affordable Care Act (ACA)

In May 2016, the U.S. Department of Health and Human Services (HHS) published a final rule under Section 1557 of the ACA to protect individuals from discrimination in health care on the basis of race, color, national origin, age, disability, and sex, including discrimination based on pregnancy, gender identity, and sex stereotyping. Section 1557 is enforced by the HHS Office for Civil Rights, the federal agency that enforces HIPAA.

Dental practices may be required to comply with Section 1557 if they receive certain kinds of government funds, such as Medicaid or CHIP funds, or "meaningful use" payments. Non-compliance may result in fines, and the Section 1557 final rule allows an individual or entity to bring a civil action (lawsuit). The specific requirements of section 1557 of the ACA are complex. CNA recommends that dentists consult their attorneys and refer to resources available from the American Dental Association (ADA.org) or other sources for further information. Note that in mid-2019, organized dentistry voiced support for proposed revisions to Section 1557. Stay up-to-date to understand the potential impact on dental practice.

Establishing Professional Negligence

Malpractice lawsuits in the United States are civil causes of action based upon the principles of tort law. In the broadest sense, a tort is any civil wrong, other than a breach of contract, for which the law will provide a remedy in the form of an action for damages.

A patient must establish four elements to prove negligence on the part of a dentist:

1. **Acceptance of a Patient (Creation of Duty).** When a dentist accepts or undertakes to render care to a patient, a dentist-patient relationship is created and the dentist incurs a legal duty to employ the requisite skill, care and knowledge ordinarily possessed by members of his or her profession. This duty is known as the "standard of care."
2. **Breach of Duty.** A dentist who fails to possess or exercise the skill, care and knowledge ordinarily used by reasonably qualified dentists practicing under the same or similar circumstances fails to adhere to the standard of care and breaches the duty owed to the patient.
3. **Causation.** In addition to establishing breach of duty, the plaintiff must show both an actual and foreseeable causal connection between an act or omission of the dentist and the resulting injury.
4. **Damages.** The plaintiff must prove an actual loss or injury incurred due to the dentist's breach of the standard of care. Such losses frequently include disability, lost wages, disfigurement, pain and suffering, past and future medical expenses, and other financial losses.

When responsibility begins

As stated previously, a dentist-patient relationship must exist in order for a dentist to be legally liable for a professional error or omission. Audience discussions at risk management seminars reveal that many dentists may not understand when their legal responsibility to a patient begins. Interestingly, some dentists may fail to consider their initial evaluation or examination of a patient to establish the creation of the dentist-patient relationship. However, seminar attendees understand that a dentist can be held liable for failing to diagnose a cancerous lesion or other pathology during the first examination. This incongruity leads many practitioners to harbor the incorrect view that an individual is not a "patient of record" if the patient was only seen on one or two occasions or never accepted a treatment plan.

For risk management purposes, dentists should consider their legal responsibility, and the dentist-patient relationship, to begin when the dentist first:

- Examines a patient
- Provides a diagnosis or treatment to a patient
- Offers professional information or opinion that a reasonable person relies upon to one's own detriment.
- The formation of this relationship pertains to any "bad advice" given by the professional, irrespective of the location (your office or otherwise) or circumstances under which it is given.

Regardless of whether the dentist-patient relationship abides for twenty minutes or twenty years, the dentist is responsible for practicing at or above the standard of care throughout its duration.

When a **dentist accepts** or undertakes to render **care** to a patient, a **dentist-patient relationship** is created and the dentist **incurs a legal duty** to employ the requisite **skill, care and knowledge** ordinarily possessed by members of his or her profession. This duty is known as the "**standard of care**."

Standard of Care

The standard of care is what a reasonable and prudent practitioner would do under the same or similar circumstances. Although the *concept* is widely understood, there are no definitions of what is or is not "reasonable and prudent" for each dental procedure.

A reasonable and prudent dentist should act with skill and due care when treating patients. Exercising due care involves:

- Informing the patient of the diagnosis
- Referring when indicated
- Obtaining the patient's informed consent prior to treatment
- Completing treatment that has been started
- Schedule any necessary follow-up visits

The standard of care is a dynamic concept, changing over time with new technology, research and advancements in clinical methods.

In a malpractice action, the standard of care is articulated through the opinion testimony of expert witnesses. Expert witnesses are professionals with background and training similar to the defendant, typically from the same practice community, who give their opinion to the court regarding the allegations in the complaint. Since the testimony given by experts is *opinion testimony*, the courts afford expert witnesses immunity from liability with respect to their testimony. This immunity promotes the free exchange of ideas permitting experts to testify without fear that a plaintiff or defendant could sue them for their testimony.

In cases involving treatment that falls within the scope of what a specialist would ordinarily provide, the plaintiff (patient) customarily retains a member of that specialty as an expert witness. As a result, the standard of care is defined by the specialist, regardless of whether the defendant dentist is another specialist or a general practitioner. Thus, if you are a general practitioner who performs endodontic therapy, you will be held to the standard of care as defined by an endodontist in claims arising from such treatment. The specialty standard of care applies to treatment ordinarily performed by other specialists.

There are exceptions, however. In some states, only a dentist with similar training and experience to that of the defendant dentist is permitted to testify as an expert witness. In such states, for example, a defendant general practitioner would be confronted with another general practitioner as the plaintiff's expert. Specialists would be barred from testifying as expert witnesses. Therefore, consult with your attorney regarding specific laws and rules governing expert witness testimony in your jurisdiction.

Another factor that juries consider when determining the standard of care is educational curricula, including what is taught both in dental schools and in continuing education courses. If you use unproven or outmoded procedures, materials, or techniques, a jury may question whether you are practicing within the professional standard of care. For example, the omission of a rubber dam during an endodontic procedure would prove difficult to defend, as all U.S. dental schools teach that a rubber dam should always be employed. Conversely, treatment of an experimental or investigational nature is often portrayed by plaintiffs' attorneys as failing to meet the profession's standard of care. Such treatment may include therapies that have not obtained regulatory clearance or approval for marketing in the United States.

It is very important to understand your state dental practice act, since these statutes often include express specific language addressing the standard of care. Also note that the current American Dental Association Principles of Ethics and Code of Professional Conduct is incorporated into many states' dental regulations or professional requirements: see the Legal section of the manual bibliography for a link to the Code on the dental association website. In a dental professional liability cause of action, a violation of the dental practice act is often presented as a *per se* breach of the standard of care.

Vicarious Liability

The legal theory of vicarious liability holds employers responsible for the acts and omissions of their employees. Vicarious liability is based on the legal concept of *respondeat superior*, which holds the "master" (employer) responsible for the acts or omissions of its "servant" (employee). When a person employs another for his or her own profit, fairness demands that the person also bear responsibility for managing the risks and paying for the damages associated with the employee's work. Dentists, as employers, are, therefore, vicariously liable for the negligent conduct of employees acting within the scope of their employment. Such individuals include employee dentists, clinical auxiliaries, and non-clinical staff.

Vicarious liability risks are typically clinical in nature, although they can be based upon errors or omissions of communication. For example, the patient asserts that he or she was given incorrect clinical information, or was never told the correct clinical information by a staff member. Fortunately, such claims are not common. Far more frequent are claims arising from a patient's dissatisfaction with staff interaction, especially when the patient believes the employee has impeded the ability to see or speak with the dentist.

Vicarious liability is an important concept in both risk management and patient management. Even when the services provided by the dentist meet the standard of care, an employee in the office may do or not do, say or not say something that will negligently cause a patient injury. Employee conduct thus significantly expands the risk to both the patient and to the dentist.

Vicarious liability for the actions of others is not limited to employees. In general, patients can reasonably expect all of the personnel they see in your office to be supervised by you. The fact that a dentist, hygienist, dental assistant, massage therapist, nurse or esthetician is an independent contractor (IC) may have tax and benefit consequences distinguishing him or her from employees. However, the independent contractor status may be irrelevant in terms of vicarious liability. For example, a dentist who enters into a contract with an independently contracted hygienist will be subject to vicarious liability exposure for the conduct of the contracted individual. Once you have assumed a certain degree of authority over your personnel, employed or contracted, you also share their risk.

Is this just? The courts and legislatures have tended to reinforce the concept of vicarious liability through judicial decisions and statutory measures, even if it seems unfair to the dentist employer. The law in all states is clear that an employer is responsible for the negligent actions of his or her employees within the scope of their employment. Courts have stated that if the law was not structured in this manner, employers would be more likely to delegate responsibility for making important healthcare decisions to unqualified employees — without any recourse or redress available to injured patients. The concept of vicarious liability creates potential repercussions, motivating most employers to delegate only to responsible employees, to appropriately train employees, to hire skilled employees and to replace those who will not follow established policies and procedures.

If vicarious liability did not exist, patients who suffered identical injuries under slightly different circumstances would not receive comparable compensation. The patient who received bad advice directly from the dentist would be able to pursue compensation under such a tort system. However, the patient who suffered an identical injury from the same advice given by the dentist's employee would be unable to pursue a cause of action.

Independent contractor and employee dentists also may be liable for the actions of dental personnel whom they supervise, but do not employ. In an analogous scenario, consider the independent contractor general surgeon who performs an appendectomy in a hospital operating room, surrounded by nurses and support staff who are not his employees. The surgical nurse is a hospital employee and thus creates vicarious liability for the hospital. During the surgery, however, the nurse also is working under the direct supervision of the independently contracted surgeon. The surgeon performing the procedure is responsible for ensuring that the nurse's actions, such as counting surgical sponges, are performed properly and meet the requisite standard of care. If a sponge is mistakenly left inside the patient, both the surgeon and the hospital will be vicariously liable on the claim.

Similarly, an independently contracted or employee dentist may be the only dentist in the office at a particular time, and is practicing with the support of the staff employed by the owner dentist. Then, imagine a patient is injured by the actions of a dental assistant or hygienist during this time. Which dentist is responsible? The answer is both. Both risk and responsibility are shared in this situation. Independent contractor and employee dentists cannot assume they are immune from legal responsibility simply because they do not pay the salaries of those whom they supervise.

Managing the Risks of Vicarious Liability

Recognizing risk factors

The risk of vicarious liability claims is higher in practices that have:

- Inferior leadership by the dentist-owner and/or delegation to unqualified personnel
- Poor selection of staff
- Inadequate office policies, procedures and staff training programs
- Poor supervision and/or staff evaluation
- Poor understanding among staff of duties and responsibilities

Controlling the risks

Vicarious liability can represent a significant area of vulnerability for dentists. Nevertheless, the techniques used to reduce vicarious liability risks also provide a higher quality of patient care. The following suggestions can help you minimize vicarious liability risks:

- Consider the professional conduct of your employees as extensions of your own — and ensure that staff also view their actions in this manner.
- Foster a positive attitude and open communication in your practice. Do not encourage staff members to obstruct patient access to you.
- Hire qualified staff members with good communication, interpersonal, and technical skills who can project the desired image of the practice.
- Establish thorough, written policies and protocols that give direction to your staff. Review policies at least annually, or as needed to remain compliant with clinical, legal or regulatory changes.
- Clearly document the duties and responsibilities of each staff position in a written job description.
- Examine the job and employment credentials of all applicants, including salaried employees, hourly employees and independent contractors. Check with the references listed on résumés.
- Background checks may be considered, though it is important to understand and comply with state and/or federal anti-discrimination laws. Consult an attorney experienced in employment law for professional advice in this area. Useful information also may be obtained on the U.S. Equal Employment Opportunity Commission website. See the Legal section of the manual bibliography.
- When evaluating prospective job applicants, keep in mind that tasks can be taught, but kindness, empathy, and concern are qualities that are not easily learned.
- Verify current credentials of all employees whose job responsibilities require licensure or certification.
- Establish clear, written performance expectations for staff.
  - For example, instead of informing your receptionist that a job function is answering the telephone, direct her to answer the telephone in three rings or less, stating the words or script you desire, using a pleasant tone of voice.
- Review your state dental practice act — you and your employees must practice within the limitations imposed by this statute.
  - Do not assign duties to auxiliaries that fail to comply with the dental practice act.
- Conduct performance reviews at least annually.
- Provide adequate training for staff members.
- Encourage and financially support staff attendance at continuing education courses that update their knowledge and skill.
- Certify your staff in CPR (cardiopulmonary resuscitation).
- Supervise each employee from the outset of employment to ensure that the employee has adequate knowledge and skill to perform assigned duties.

Vicarious liability can be a significant **area of vulnerability** for dentists. The **techniques used to reduce** vicarious liability **risks** also provide a **higher quality of patient care**.

- Hold regular staff meetings to strengthen office policy and improve staff communication.
  - Use staff meetings to discuss office successes and/or shortcomings, resolve problems or other office practice situations that need improvement, and educate your staff. Incorporate patient safety and risk management topics in all staff meetings.
- Respect and show confidence in your staff, especially when patients are present.
- Review your professional liability insurance policy to determine whether it includes vicarious liability coverage. (For example, professional liability policies for dentists and dental specialists issued through CNA include this coverage.)
- Through the use of surveys and evaluations, ask patients for feedback about your practice and include your staff as an evaluation subject. This tool will assist in gaining insight into patients' perceptions of your staff and the quality of staff-patient interactions.
- Require a certificate of insurance from all independent contractor dentists. Confirm that you are listed as an additional insured on each of the other dentists' policies.
- Ask independent contractors or other dentists sharing your space to sign a hold harmless/indemnification provision, which indemnifies you against any losses arising from their activities. (As these clauses are varied and complex, consult with your personal attorney before signing any contracts containing a hold harmless provision.)
- Ensure that the other dentists' insurance policies cover contractually assumed liability.

The Importance of Staff in Managing Risk

Dentistry is a team business. No matter how or where you look in a dental practice, dental staff are vitally important to every aspect of the practice. The ability of staff to help manage risk is critical to an effective patient safety and risk management program.

Chairside dental assistants make clinical procedures safer for patients and increase dentist productivity. Dental hygienists provide clinical care and also educate patients. Front desk staff represent the public face of the practice, the first office representatives to whom the patient will speak by phone or meet in person. Patients' first impressions of them can have a profound effect on the practice. Financial personnel are charged with ensuring the cash flow of the practice and are given the task of managing accounts receivable. Whatever their role, staff members influence patients' opinions of the practice as well as their sense of satisfaction.

Why is this important? We know patient dissatisfaction is a significant factor in dental professional liability claims. Approximately 80 percent of CNA closed dental claims do not result in a payment to the claimant. Although exceptions exist, the majority of these claims probably were not instituted solely because of poor dentistry. Rather, they were pursued due to patient dissatisfaction arising from non-clinical issues. With multiple patient contacts in a variety of interactions, the dental staff has a profound ability to improve patient satisfaction and reduce the likelihood of a professional liability claim. The ability of your staff to positively affect patient views is a separate, yet related, risk management issue from that of vicarious liability.

Apparent (Ostensible) Agency

Vicarious liability is not limited to liability resulting from the actions of employees or independent contractors (ICs). It also may arise from the actions of anyone with whom the dentist has, *or appears to have*, a supervisory relationship. This application of vicarious liability involves the legal theory of apparent agency, also called ostensible agency.

The theory of apparent agency applies, for example, when an owner dentist utilizes an independent contractor (IC) associate dentist in the practice. Ultimately, the IC leaves the practice for another professional opportunity and the care of his patients reverts back to the owner dentist. The owner dentist then either receives complaints from patients about the care of the former associate or directly finds evidence of inadequate care. In either case, the owner dentist had not performed the treatment himself and directs the patient to pursue correction of the problem by the former IC at his new location. The former associate likewise tells the patient to pursue the matter with the owner dentist, since the payment check was made out to the owner dentist's practice entity. As each dentist attempts to deflect responsibility to the other, the patient is dissatisfied with the failure to respond to his or her concerns. So who must accept responsibility for the work performed?

State legislatures typically do not enact laws that address who has primary liability in this type of case. Therefore, who is accountable depends upon the parties the patient opts to pursue. The patient may pursue correction and/or reimbursement from the clinician who actually provided the care, the IC who has left the practice, or the business entity to whom professional fees were paid, the owner dentist. Or the patient may pursue all of these parties. Therefore, a shared responsibility exists for the two dentists, both for clinical outcomes and the financial costs. Both have potential liability, and it is in the best interest of each dentist to try to address the patient's needs.

Some dentists mistakenly believe that they can insulate themselves from liability in such cases by paying the associate as an IC rather than as an employee. Regardless of Internal Revenue Service or other accounting tests for independence, an important liability consideration depends upon whether the patient had a clear understanding of the independent status of the IC. If a patient held a *reasonable belief* that the other practitioner was associated with your practice, or that you were in some way a supervisor or manager of the IC, that practitioner may be considered your "apparent agent." Thus, it would become difficult for you to fully extricate yourself from responsibility.

The closer the apparent connection between the dentists, the more reasonable the patient's belief and the greater the potential for apparent agency liability. For example, the fact that fees are billed by and paid to the owner dentist's practice, rather than directly to an IC, would be one aspect of apparent agency. The payments to the owner would lead a reasonable person to believe that the IC worked for his practice. A common practice telephone number and shared support staff also fail to support the claim of separate entities. In addition, is there signage on the wall or an information sheet given to patients that explains the separate nature of the practices? If not, a reasonable patient may believe the IC works for the owner dentist's practice.

By identifying the independent status of the dentist in question, you may be able to reduce the risk of liability under the theory of apparent agency. A clear disclaimer of responsibility may reduce your risk in such circumstances. Some additional strategies to diminish the risk of apparent agency liability include:

- Place IC names in a separate location on the building marquee. The more obvious the separation, the more likely a reasonable person would question whether the two practices were affiliated.
- Include a demarcation between the primary dentists' names and the IC's name on entry and exit doors. Again, a reasonable person should observe an apparent separation between the practices.
- Produce a brochure that lists the practice hours, the services performed, and the names of the dentists in your practice. Inform readers of the brochure that the IC is not associated with your practice. The IC also could produce a brochure for his or her patients with corresponding information.
- Add a clause to the agreement between you and the IC requiring the independent dentist to inform each patient of the separate nature of the practices. This procedure would limit the potential for an apparent agency liability claim.
- Ensure that brochures and other information concerning the IC's practice are not available to your patients, and vice versa.
- Expressly inform patients at the time of any referral to the IC that his or her practice is independent of yours, even though that dentist leases your office space.

Informed Consent

Informed consent represents the exclusive right for patients to determine what is done to their bodies. In the United States, it has developed primarily over the past century from the legal concept of battery, which is the unauthorized touching of another person. Through the years, numerous legal cases have affirmed the healthcare provider's duty to obtain a patient's informed consent before treating.

Informed consent is the process through which a patient is provided sufficient information to make an informed, reasoned decision regarding the proposed treatment or procedure. The consent must be given without coercion or fraud, based upon the patient's reasonable understanding of what will take place.

Except in an emergency situation, whenever you ignore the wishes of a patient and proceed with treatment without the necessary consent, you may be subject to malpractice litigation. Litigation may ensue notwithstanding your professional opinion that treatment was in the best interest of the patient. By pursuing the treatment, you also may have committed the criminal offense of battery.

Most patients have a reasonable idea of some dental procedures that occur during routine examination or treatment. Thus, patients imply their permission to have work performed when they visit an office for routine care. Implied consent. However, the concept of implied consent has severe limits as a legal defense. Dentistry is a highly technical profession, and patients often have a limited understanding of the procedures to be performed. The law employs the concept of informed consent to protect patients from making uninformed decisions about their welfare.

We encourage dentists to consider the informed consent process as an educational experience, with the patient as the student and the dentist as the teacher. Although staff members, brochures, and electronic equipment can assist in educating the patient, the dentist bears ultimate responsibility for informing the patient.

The informed consent process involves two main components:

- Discussion, including disclosure and patient education
- Documentation in the patient record, which often includes the use of a written informed consent form

Although some dentists may consider the informed consent process burdensome and time consuming, it has a number of positive risk management effects. The informed consent discussion represents the first step in managing the patient's expectations for treatment outcomes and reducing the possibility of a misunderstanding. Patients who have an understanding of the risks of treatment will be less likely to institute a malpractice claim if one of the described risks actually occurs. In addition, healthcare information record documentation of the informed consent process provides the best defense against a patient's allegation that he or she was inadequately informed about the proposed treatment, the treatment options available, or the potential for injury. Furthermore, a patient instituting a claim based upon "lack of informed consent" must prove that informed consent was not provided. Good communication and documentation by the dentist will increase that burden and act as a deterrent to allegations of a lack of informed consent in the event that a claim arises.

Many claims of professional negligence are accompanied by an allegation of a lack of informed consent. In such an action, the patient may contend that the dentist was negligent in not properly educating the patient. Moreover, if the patient had known in advance of the treatment or procedure that a bad result was possible, he or she will further allege that consent would have been withheld.

Typically, claims do not solely allege lack of informed consent, without other claimed damages. In many instances, the dentist has met the standard of care in the delivery of services, yet the patient was dissatisfied, often due to a lack of communication. In today's consumerist environment, the informed consent process assumes greater importance as a vehicle for patient education, dentist-patient communication, and sound risk management.

Informed Consent Discussion

Informed consent is a process, not a specific document. The process requires a verbal component regardless of whether a written form is used. As such, a patient can give an oral informed consent. An exclusively oral informed consent is valid in most jurisdictions. However, individual state requirements govern and a number of states require written informed consent. As a practical matter, a written informed consent form memorializes and thus documents that the protocol was implemented. The goal of informed consent remains the same whether you have an oral discussion exclusively or also use a written form: the patient must have an adequate understanding of the proposed treatment to provide you with the consent necessary to begin treatment.

Your diagnosis and treatment plan should serve as the framework for your informed consent discussion with the patient. The information provided as a basis for informed consent will differ based upon the complexity of treatment and on the degree of risk presented by the proposed treatment. For example, the information for orthognathic surgery consent should, therefore, be significantly more detailed than for a facial composite resin discussion. Treatments which are within the understanding of the patient, either through past experience or general knowledge, require a less detailed explanation.

Components of informed consent

The doctrine of informed consent requires that the patient be given sufficient information about, and consider, three major components, which you are required to disclose and discuss with the patient. They are:

1. Nature of the proposed treatment

The discussion regarding nature of the proposed treatment should include the:

- necessity for treatment
- anticipated benefits of treatment
- prognosis of treatment
- time involved
- cost involved

Information pertinent to the *nature* of the proposed treatment should explain why your diagnosis justifies the *need* for treatment. State your diagnosis and indicate the *benefits* of your recommended treatment, including comparison with other treatment options.

An approximation of the *prognosis* of the treatment is required. No dental provider can, or should, promise a specific prognosis to a patient. Indicate the prognosis in general terms such as excellent, good, fair, or poor. Give the prognosis for the "big picture," not simply for the procedure at hand, as the patient has a right to consider all pertinent information when determining a course of treatment. More extensive discussions with the patient about any treatment recommendation with only a fair prognosis would help the patient make a more informed decision. Treating patients with a poor prognosis is a risky proposition and should be avoided. Moreover, patient demands for and consent to treatment options that are not in the best interest of the patient may breach the standard of care. Refuse to provide care in these circumstances as the dentist must always practice in conformity with the standard of care, regardless of patient demands.

Advise the patient of an approximate *cost* of the treatment, and estimate the *time* involved. Cost is not an element of the informed consent doctrine, *per se*, but more patients tend to make treatment decisions based on finances than on any other single factor. Therefore, the expenses should be included in the discussion. Always update the patient whenever there is a change in cost, time or prognosis.

Financial issues are the most common reason claims are instituted against dentists. Patients who believe they were not provided full disclosure of their treatment fees in advance of the treatment often feel deceived. They may perceive the lack of full fee disclosure as tantamount to a "bait and switch" tactic to lure them into a costly commitment to the dentist. Clearly, these perceptions are potentially damaging to the dentist-patient relationship, as well as the patient's oral health in circumstances in which the patient cannot afford to continue with care.

Consequently, we recommend that dentists disclose the cost of the informed treatment decision at hand (e.g., RCT vs. extraction), as well as the approximate cost to complete the various treatment alternatives available. For example, inform the patient of the cost of the root canal, including the buildup, the periodontal crown lengthening, and the crown as one option. Treatment option two includes the cost of the extraction, plus the bone graft, plus the implant fixture, plus the implant abutment hardware, plus the crown. Option three includes the cost of the extraction, plus the cost of the bridge. By fully disclosing the fees, you minimize the likelihood of a financial misunderstanding that leads to frustration for both you and the patient.

2. Alternatives to the proposed treatment

The discussion of the reasonable alternatives to the proposed treatment should include the following:

- when the proposed treatment falls within what a specialist would customarily perform in that specialty, the alternative of specialty referral should be offered
- the alternative of no treatment, when appropriate

You are not ordinarily required to list every available alternative procedure. However, the alternatives must contain those procedures most relevant to specific patients and their oral and overall health conditions. The alternatives presented are typically those that have a better prognosis, are less costly, involve less time, require less follow-up care, or are less irreversible. Patients should be told why the recommended treatments are preferred over the alternatives. Patients should understand at what point in the treatment certain alternatives will no longer be available.

It also may be necessary to discuss alternative treatments that you do not personally perform. For example, a patient is congenitally missing tooth #7 and wears a flipper partial denture. You do not place or restore implants in your practice and would customarily treatment plan a bridge from #6 – 8. However, an implant and crown may be the preferred alternative to a fixed bridge, depending on the clinical circumstances and other factors. Therefore this option should be offered as a potential treatment option, while acknowledging the need for referral to another dentist for this alternative.

3. Foreseeable risks

The discussion of the foreseeable, material risks and potential complications of the proposed treatment should:

- define a foreseeable, material risk as one which has a reasonable likelihood of occurring and about which a reasonable person would be assumed to take an interest.
- advise the patient of the risks of refusing the recommended treatment

Similar to the discussion of alternative treatments, the list of potential risks need not be all-inclusive, but it should be pertinent to the patient's oral and overall health. Concentrate on risks likely to occur, such as swelling after an extraction or root sensitivity after scaling, or those with high severity, such as postoperative infections, tooth loss, and nerve injury/paresthesia.

To be considered "informed," the patient must be given sufficient information upon which to base a decision *and* understand that information. In order to assess both your level of disclosure and the sufficiency of the patient's understanding, you may wish to determine whether the patient is able to pass a "quiz" about the proposed treatment. The patient should have the ability to answer three basic questions that relate to the main components of informed consent. Ask the patient:

1. What treatment is proposed and why has it been recommended?
2. What other choices do you have?
3. What negative consequences may occur as a result of (or lack of) the proposed treatment?

The next step is for the patient to state his desire to either pursue or decline the proposed treatment. The patient has a legal right to decline your treatment recommendation and refuse care. (See the "Informed Refusal" section later in this chapter for more information.)

To be considered **"informed,"** the **patient** must be **given sufficient information** upon which to base a decision and **understand** that information.

Informed consent discussion suggestions

Lawyers and judges have noted that how something is said is equally as important as what is said. We recommend that the treating dentist lead the informed consent discussion when obtaining informed consent.

- The oral discussion with the patient should be approached with empathy and reason, and should be tailored to the needs of each individual.
- Use basic, uncomplicated language that the patient will understand. If you use technical terms, provide explanations. Limited oral health literacy is a significant barrier to effective informed consent discussions.
- Present your need to obtain informed consent as a benefit to the patient. When patients understand that the discussion is for their own best interests, they will be more receptive and cooperative with the process.
- Treatments that are within the understanding of the patient, either through past experience or general knowledge, need not be explained in as much detail.
- Provide information based upon the complexity of treatment and on the degree of risk presented by the proposed treatment.
- Use brochures, pamphlets, models, educational DVDs and discussions with your staff to provide the patient with additional information about the proposed treatment.
- Give the patient every opportunity to ask questions. You should answer the questions as clearly and thoroughly as possible, and evaluate — and correct, if necessary — the patient's understanding of your replies.
- Where appropriate, encourage the patient to have a family member present in the room during the informed consent discussion, both for emotional support and to assist in achieving an understanding of the information.
- On occasion, it may be desirable for you to have a staff member present during the informed consent discussion to witness the discussion and make the patient feel more at ease.
- When treating a minor, obtain the informed consent of the parent or guardian prior to beginning treatment. A minor cannot consent to his or her own treatment unless legally declared emancipated by the court or determined to be emancipated pursuant to state law.
- Secure the patient's informed consent at an appointment prior to the treatment visit whenever possible. The return on the date of treatment is further validation of the desire to receive the recommended treatment.
- Although staff members can assist in the informed consent process by helping to educate the patient, the patient *must* be given an opportunity to speak with, and ask questions of, the treating dentist before treatment begins.
- It is ultimately the responsibility of the treating dentist to ensure that the patient understands what has been presented. Always ask the patient, "Do you have any questions about the information you have been given or about the proposed treatment?"
- Ask for the patient's approval to perform your recommended treatment. Remember that any treatment rendered without the patient's consent may result in allegations of battery or other charges.

Communication problems

- If your patient cannot understand the informed consent process due to language or other barriers, then you cannot obtain the necessary *informed* consent.
- If you or a staff member do not speak the patient's language, invite the patient to bring a family member or friend to translate, when needed. Be aware that depending upon circumstances and your state law, you may be required to provide translation services free-of-charge for patients with limited English proficiency (LEP). If your practice accepts federal funds (e.g., treatment of patients covered by Medicaid), federal law may require providing translation services for LEP patients.
- Thoroughly document who translated and what was said. Include the translator's name, address, and telephone number in the body of your progress note for that day.
- If you routinely treat patients who speak the same foreign language, have your consent forms translated into that language to facilitate the informed consent process.

Informed Consent Documentation

In dental professional liability litigation, the defendant dentist often must present documented (verbal, written, or recorded) evidence in court to prove that an informed consent discussion was conducted. There are two important elements to informed consent documentation:

- Verification that the discussion occurred, and
- Evidence that the patient understood and agreed to the treatment procedure.

Whether supplied orally or in writing, receipt of the patient's informed consent must be documented in the patient record. A written description of the informed consent discussion, signed and dated by the patient, serves as the best evidence of this discussion. Typically, a pre-printed form that permits the dentist to insert specific information, where appropriate, is used.

Regardless of whether a written informed consent form is used, the dentist should write a progress note that reflects the specific consent process for that patient. Your entry should include:

- What was discussed
- What questions were asked
- What answers were given
- Who was present, including staff and friends and/or family members of the patient
- What documents, brochures, or handouts were given to the patient and/or what patient information videos were viewed
- That informed consent was given by the patient

Your level of documentation should correspond with your assessment of risk for the recommended treatment and your comfort level with both the patient and the procedure. While it may be efficient to write a simple progress note that includes the abbreviation "RPIC" for "received patient's informed consent," both a detailed progress note and a written customized document are preferable. Another brief and often-used progress note is, "informed consent signed." While this may be an accurate statement, it fails to document that the required discussion took place.

An alternative documentation method includes a notation in the patient's chart stating the important elements of the informed consent discussion, with a patient signature on the record entry. Examples of customizing the entry to the patient include listing additional important information regarding alternatives and risks ("patient understands the possibility of numbness...") and specific questions answered ("patient asked about possible swelling; I advised her that moderate swelling was likely…").

Be aware that a cursory entry reading "risks, consequences, and alternatives were discussed" has significant limitations. The dentist would still be required to explain in court the express discussion, without being able to refer to a comprehensive record of the specific points and topics covered.

Whenever adjunct aids are used, their use should be documented in the patient's healthcare information record. Documentation can easily be completed with abbreviations or short notations, such as "Pt. and mother viewed RCT DVD #3" or "Pt. given implant pamphlet #12-B." Then, you can refer back to the DVD or pamphlet if questions arise in the future. Such substantiation also serves to document your education of the patient. Keep in mind that an informed consent form is also an excellent tool for educating patients.

Ultimately, if a "lack of informed consent" claim is heard in court, a jury will determine the adequacy of the informed consent. A signed form does not guarantee that the defendant dentist will win a case of this nature. However, documentation of the informed consent discussion and the patient's admitted understanding of the discussion will aid in the defense of a "lack of informed consent" malpractice allegation.

Risk management topics such as informed consent are still uncommon in the dental literature. However, at least two systematic reviews on informed consent have been published recently in the Journal of the American Dental Association (August 2016 and April 2017).

Please refer to page IX for information about access to a sample form on "Discussion and Consent for Treatment."

Written Informed Consent Forms

Developing a written informed consent form

Written informed consent forms are used to supplement, but not replace, informed consent discussions. Most patients do not remember all that they were told during the informed consent discussion, making written forms a valuable reminder to both the patient and the dentist.

Effective informed consent forms should be customized to both the patient and the procedure. Following the informed consent discussion, the patient is asked to sign the form. An effective form will help direct the discussion and serve as a reminder to the dentist to cover certain important points. Think in the context of educating the patient to pass the 3-question quiz noted earlier. In addition, the dentist should sign the form and retain a copy in the patient's chart.

Written informed consent forms should:

- Use simple, plain language that the patient will understand.
- Specify the name of the dentist who will be providing care.
- Specify the name of the treatment(s), procedure(s), or test(s).
- Discuss the nature of the proposed treatment, its necessity and benefits.
- List available alternative treatments to the recommended treatment.
- Discuss potential complications and general risks of the recommended treatment and any specific risks for this patient.
- Permit you to customize the form for each patient using checklists and/or fill-in blanks.

Some dentists also include blank areas for patients to describe, in their own words, their understanding of the discussion. Written patient comments serve to verify that the patient has understood the information presented.

Suggested dental procedures for using a written informed consent form

We recommend written informed consent forms for procedures with high claim frequency, a significant risk of injury, and those having the potential for patient misunderstanding. The informed consent protocol should be implemented for various procedures, including but not limited to, procedures such as:

- Extractions
- Root canal treatment
- Crown and bridge
- Implants (both placement and restoration)
- Surgery involving incision and flap reflection (perio, endo, preprosthetic, etc.)
- Pediatric dentistry, including behavior management
- Cosmetic dentistry
- Orthodontics
- TMD treatment
- IV sedation or general anesthesia (use a separate consent form)

We also recommend that you employ a written informed consent form with patients who may present an increased risk, perhaps due to an argumentative nature or forgetfulness. In practical terms, you may use a written informed consent form for any procedure you choose. For simple procedures, such as operative dentistry, an informed consent form may seem impractical. But what if you're placing a large direct MODB composite on #30 due to deep recurrent decay around a 30-year-old amalgam? It is an operative procedure, but one with a significant risk of a pulpal exposure or pulpal trauma that could lead to root canal therapy and a crown. Does the patient know of these risks and accept them?

Written informed consent form suggestions

Procedurally, the use of written informed consent forms should include the following protocol:

- Give the form to the patient on a date prior to the treatment date so the patient has time to think about the decision. (Due to emergency treatment needs, it may not be possible to pursue this timeframe.)
- Ask the patient to sign the form, although a patient signature is not necessary to prove that an informed consent discussion took place.
- Retain the original form in the patient's chart to document the specific information given to the patient, then document the use of the form in the progress notes.
- Give the patient a copy of the form.

Informed Refusal

An informed refusal is essentially the opposite of an informed consent in that the patient has said "no" to the procedure instead of "yes." The information presented to the patient is the same for both processes, until the patient declines the recommendation. From that moment, the dentist is required to provide more information to the patient.

The patient has a legal right to decline your treatment recommendation and refuse care. If this occurs, you must explain to the patient the consequences and foreseeable risks of refusing treatment. Also ask about the patient's reasons for refusing care. If the patient states, or if it appears, that the refusal is due to a lack of understanding, re-explain your rationale for the procedure or treatment, emphasizing the probable consequences of the refusal.

The dentist's disclosure of the consequences of the refusal is a critical aspect of the informed refusal process. For example, a patient who declines scaling and root planing must be informed of the progressive nature of periodontal disease and that his condition will worsen more quickly without treatment. A patient who declines to have impacted #32 removed must be informed of risks such as follicular enlargement leading to bone destruction, pain, pathologic fracture, and nerve damage. If the patient again refuses to accept your treatment recommendations after you have communicated the risks of refusing treatment, then the patient has given an *informed refusal*.

Numerous malpractice lawsuits have been filed against healthcare providers by patients who asserted that, upon suffering a serious injury after refusing care, they did not fully understand the potential consequences of such refusal. In a typical situation, a patient contends that the healthcare provider was negligent in not fully disclosing the risks of treatment refusal. Coupled with this allegation is the patient's assertion that he or she would have consented to the procedure or treatment if the risks of refusal had been properly and completely explained by the healthcare provider.

Informed Refusal Options

A patient who has refused your treatment recommendation presents you with two choices. You can

- Continue to treat the patient — within the outline of the parameters to follow
- Dismiss the patient from your practice due to noncompliance

There is no right or wrong decision, simply a matter of preference. Your decision may vary from patient to patient, depending on your risk assessment for continuing to treat each individual.

Each choice presents some level of risk to your practice. If you decide to continue treating, you risk the possibility that at some point in the future, the patient's condition or treatment recommendations may not be adequately evaluated or documented. If you decide to dismiss the patient, you risk alienating him and spreading his ill will to other patients he knows. Your decision will be based on a myriad of factors, including the quality and longevity of your dentist-patient relationship, the nature and urgency of the recommended treatment, and the overall financial impact on your practice.

Continuing Duties

The dentist who retains the refusing patient in his or her practice and continues with care must be aware of several additional duties relating to the patient's informed refusal. These duties are imposed in addition to the informed refusal discussion.

They include:

- A continued duty to *examine* and *diagnose* the patient's condition for the duration of the dentist-patient relationship and as long as the patient continues to refuse treatment
- A continued duty to *inform* the patient about the condition and its associated risks while the dentist-patient relationship exists, the condition exists, and the patient continues to refuse treatment
- A heightened duty to tell the patient how treatment refusal might affect future treatment options, other oral/body structures and/or overall health.

The failure to meet these obligations has resulted in numerous *failure to diagnose* and *failure to inform* allegations. A positive trend has developed inasmuch as fewer of these allegations have arisen in recent years. A typical claim involves a patient who refuses scaling and root planing but is agreeable to return on a regular basis for debridement by the hygienist. Since the patient has not demonstrated an interest in improving his periodontal health, the

dentist does not emphasize periodontal concerns during regular recall appointments. The dentist neither probes the periodontium nor documents in the progress notes any facts about the patient's periodontal status or diagnosis.

After a few years, the patient complains of a worsening periodontal condition, including increased bleeding and progressive mobility of teeth. Upon hearing a renewed complaint by the patient, the dentist finally re-evaluates the periodontium, observing progression from a moderate to a severe case. The patient now has severe bone loss and needs multiple extractions. Incredulous at the news, the patient questions how his mouth could have gone from needing a "gum scraping" to multiple extractions without the dentist ever discussing this situation.

CNA claim professionals find that the patient records in these claims often lack updated periodontal probing records, clinical observations, diagnoses, or documentation of having informed the patient of the disease status. The risk to the dentist lies not in the continuation of the dentist-patient relationship, but in the absence of regular evaluations and disclosure to the patient, and of documentation of these actions.

Documentation of Informed Refusal

Refusals of care represent an increased liability risk and require greater diligence on your part to manage that risk. The most effective technique is to thoroughly document the informed refusal process. Criteria for documenting informed refusals are similar to, but go beyond, those for informed consent. Following a discussion of the consequences, we strongly recommend a comprehensive progress note as well as the use of a written form documenting the refusal.

Your progress note should document:

- Who was present
- The treatment discussed
- The educational documents, brochures, handouts, or presentations given to or viewed by the patient
- The questions asked and answers given by both parties
- The patient's refusal of the recommended care
- That the patient was informed of the risks of not following your recommendations (list the specific risks you stated)
- The patient's reasons for refusal
- That the consequences of refusal were re-explained and that the patient continued to refuse the recommended treatment. Emphasize that the patient understood the risks of refusing care.

Using an informed refusal form

As noted, we also encourage the use of an informed refusal form, such as the sample form made available with use of this manual. Few patients remember all that they were told during the informed consent/refusal discussion, making written forms a valuable reminder to both the patient and the dentist. A written form also helps manage patient expectations, provides further documentation of the disclosure of information, and helps to deter negligence claims alleging a lack of informed consent or informed refusal.

Complete the form, paying special attention to the section titled "Risks of Not Having the Recommended Treatment." Then ask the patient to sign it. Some patients will change their minds and agree to treatment when presented with a written document and an insistence on their signature. Although the documentation process is not necessarily designed to persuade patients into accepting treatment, these individuals will ultimately benefit from receiving the proper care.

Of the patients who persist in refusing your treatment recommendation, some will sign the form, and others will not. While it is preferable to have the patient's signature, don't fret if you can't obtain it. Sign the form yourself and have the staff member who witnessed the discussion and disclosure sign it as well. If the patient has refused to sign, write "Patient refuses to sign this form" on the patient signature line. Regardless of whether or not the patient signed the form, place the original in the patient's chart and give a copy to the patient. Your signatures on the form, along with your progress note, will demonstrate that a discussion took place and an informed refusal was given.

The documentation process for informed refusal does not end after the first refusal. At *every* recall visit — after re-examining the patient, updating your diagnosis and informing the patient of his or her status — make a chart entry concerning the continued refusal of care. If the patient's condition as well as your treatment recommendation is the same as the last visit, re-sign and date the informed refusal document and ask the patient to do so as well. If the patient's condition, your diagnosis, or your treatment recommendation has changed, complete a new form reflecting the updated information.

Finally, note the refusal of care in the progress note for any visit during which you discuss the issue with your patient, notwithstanding that the time period between visits was brief.

Please refer to page IX for information about access to a sample form on "Discussion and Refusal of Treatment."

Special Issues in Informed Consent

Consent for Minors

As a general rule, consent for treatment offered by an unemancipated minor is not valid. The informed consent of a parent or legal guardian must be obtained before treatment is rendered. Adult siblings, grandparents, and other adult caretakers are not legally authorized to provide consent unless they have been granted legal guardianship by the court.

Regardless, dentists too frequently accept the consent of the adult party who brought the child rather than defer until the proper consent can be obtained.

Consider the situation where the parent does not accompany the child to a six-month recall appointment. If, during the clinical exam, the dentist decides that X-rays are required or that one or more carious lesions should be restored, is the consent of the parent (or legal guardian) required before such routine procedures are performed? If the parent cannot be reached by phone, is it prudent to proceed, or should the treatment be deferred until consent can be obtained?

From a liability perspective, this is a gray area. Some may contend that by allowing the child to present alone at the office, the parents have given their implied consent to any such routine procedures. More conservative risk managers would disagree, countering that while the exam and prophy might fall within an implied consent, the radiography and restorative care do not. In today's litigious environment where "lack of informed consent" is a common allegation, proceeding without consent may create a conflict between you and the child's parents. The conflict may arise even if the parents object solely to the additional professional fees.

Establishing and communicating an office policy related to unaccompanied minor patients will help to clarify this issue for all concerned and prevent misunderstandings. If you are presented with an unemancipated minor, unaccompanied by a parent or legal guardian, we recommend the following steps to minimize potential conflict and reduce liability risks:

- First, make a professional judgment as to whether any delay in treatment will be detrimental to the minor patient's dental or systemic health. Ask yourself whether it is in the patient's best interest to proceed with the treatment immediately, or whether treatment can wait until a parent or legal guardian can be contacted.
- Next, make a reasonable effort to contact the parent or legal guardian. To that end, patient charts should be updated with cellular telephone numbers. The dental record should contain documentation of all attempts to reach a parent or guardian.
- If you cannot reach a parent or guardian, defer routine treatment or, if necessary, palliate the patient's condition until a parent or guardian's informed consent can be obtained.
- Generally, it is acceptable to intervene without parental consent when immediate intervention is warranted due to traumatic injury or other truly emergent conditions.

If an unaccompanied minor child presents for an appointment for simple or routine treatment that has already been discussed and consented to by the parent or guardian, it is permissible to proceed with treatment. Be certain you do not perform any treatment transcending the limitations of the prior consent.

Although you may have obtained consent, certain appointments may arise when the planned treatment is rather involved and you wish to have a parent accompany the child. You may institute an office policy that requires a parent to be present for treatment to proceed. If you have such a policy, clearly inform parents that their presence will be necessary at that time.

The age of majority varies from jurisdiction to jurisdiction, as does the law concerning when a minor is deemed emancipated. The treatment of adolescent patients can be uniquely challenging. The hallmarks of adolescence are physical changes, increasing autonomy and sometimes a proclivity for risky behavior, as those situated between childhood and adulthood seek to understand themselves and explore the larger world. Dentists and staff members who treat adolescent patients establish a professional relationship, allowing them to develop a mutual trust and thereby gain insights into an adolescent's state of health.

During the course of care, a dental examination may signal certain sensitive health issues that, in turn, present a range of clinical, legal and ethical concerns. Contact an attorney in your area who specializes in malpractice defense for clarification of these issues.

Children of divorced parents

Obtaining informed consent from one parent is adequate. However, it is essential that the parent granting consent be legally authorized to do so. Divorces can often be highly contentious, such that some divorce decrees stipulate that a non-custodial parent is stripped of parental rights. If a natural parent has no parental rights, that individual is precluded from granting consent on behalf of his or her child.

The right to legally grant consent for a minor child is independent of any financial obligations or arrangements that may have been made during divorce proceedings. Consequently, the parent paying your fees may or may not be legally authorized to grant consent. In the best interest of the minor patient, discuss and probe these issues, as necessary, before treatment begins to effectively mitigate miscommunication risks.

Occasionally, divorced parents will disagree regarding the granting of consent for their child's treatment. From a practical perspective, it would be inadvisable to proceed until someone — a parent, grandparent, aunt, uncle or other party — first assumes financial responsibility for the care. Keep in mind that one of the most effective risk management techniques is to simply say "no" to unreasonable requests from patients and parents. Empathetically inform parents (divorced or otherwise) that you understand that disagreements may occur, but that it is essential to obtain clear direction and informed consent before proceeding with treatment of a minor patient. The dentist's role does not include arbitration of family disputes.

Decision Making, Consent, and Mental Capacity

As the number of older Americans continues to grow, dentists will be faced with an increasing number of dental, medical, ethical and legal questions when treating mentally incapacitated patients and those with impaired mental capacity due to aging or disease. This issue also pertains to patients of any age where mental capacity issues arise. Healthcare decisions, including informed consents and refusals, are valid only when patients have the capacity to comprehend and consent to treatment — and patient capacity can be difficult to assess.

There are no hard-and-fast rules to assure a dentist that the patient possesses or lacks capacity to consent to treatment. However, emergency procedures may be completed regardless of the capacity issue in life-or-death situations, provided that the urgent need for intervention is clearly determined and documented. What may seem to be a "dental" emergency from the perspective of the dentist, patient, or patient's caregiver, such as the extraction of a mobile and painful tooth, might not be deemed a true "life or death" emergency that would vitiate the requirement to obtain the consent to treatment from an individual who lacks capacity to consent. Thus, dentists involved in capacity situations must be cautious about decision making and treatment until all capacity and informed consent issues have been resolved.

There are several basic tenets that a dentist should consider when capacity is at issue:

1. All adult patients are assumed to be capable of consent unless proven otherwise.
2. Only a court can officially designate someone as legally incapacitated.
3. Evidence of a good faith effort by the dentist to determine capacity will assist a dentist if the capacity issue arises after initiation of treatment.
4. There is no standard procedure that a dentist can utilize to evaluate and unequivocally prove capacity.

However, there is information that can assist the dentist. A 1982 report issued by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research continues to offer excellent guidance in this area. The report included a three-pronged test for decision-making ability. According to this study, to be considered to have the requisite capacity, the patient must:

- Possess a set of values and goals
- Be able to communicate and understand information
- Have the ability to reason and deliberate about choices

The following questions may assist a dentist in determining and documenting a patient's capacity to understand and consent to treatment.

Does the patient possess a set of values and goals?

- Question the patient about his or her daily routine. Ask why the patient does certain things (eating meals, taking medication, reading, watching television, discussing information with a caregiver).
- Ask the patient to list the five most important things he or she does every day.
- Ask the patient to describe his or her most pressing personal issue.
- Ask the patient to describe the most pressing issue for the country.

Is the patient able to communicate and understand information?

- Ask the patient to describe the reason for the visit to your office.
- Give the patient a simple explanation of treatment needs, and ask the patient to repeat the information to you.
- Ask the patient for the following information:
  - Date of birth
  - Age
  - Current address (the patient may not know the street address, but may know the location, e.g. "my daughter's house," or "All Care Nursing Home")
  - The name of his or her closest relative
  - The name of the person who should be contacted in an emergency

Does the patient have the ability to reason and deliberate about choices?

- Before you suggest any treatment, ask the patient for any suggestions about the treatment needed. Evaluate the sensibility of that information.
- Ask the patient to describe one or two problems that may arise if treatment is not completed.
- Ask the patient to list one or two positive benefits of the treatment you have recommended.

Patients whom you believe understand and can respond adequately to these questions may be considered of adequate mental capacity to proceed with the informed consent discussion and subsequent treatment. Treatment of patients who do not fully comprehend the questions or do not provide cogent answers should be deferred until mental capacity and/or decision-making authority are investigated and resolved.

Even in situations when the patient is of sound mind, the patient's spouse, siblings and/or children may insert themselves into the informed consent process and attempt to override the patient's wishes and demand specific treatment. In these circumstances, you may choose to provide the patient with written information regarding treatment options, as well as a written informed consent form, and suggest that the parties discuss the matter further before proceeding with treatment.

Legal status of proxies

Traditionally, patients' family members were relied upon to make treatment decisions for mentally incapacitated patients. The family was considered the proxy, even without formal designation. This view was endorsed in the 1976 New Jersey Supreme Court decision, *In the Matter of Karen Quinlan, 70 N.J. 10 (1976,)* in which Karen Ann Quinlan's father was allowed to serve as his comatose daughter's surrogate decision maker.

In the aftermath of the *Quinlan* decision, several states enacted statutes addressing proxy designation through the appointment of a durable power of attorney for healthcare decision making. These statutes permit adults with the requisite capacity to appoint a proxy authorized to give or withhold consent for healthcare treatment if the designator becomes incapacitated. Dentists were legally bound to recognize the surrogate's authority unless the appointment was nullified by a court.

In 1990, however, the U.S. Supreme Court limited the authority of families to end life-sustaining treatment for incapacitated patients. The Court's decision in *Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990),* held that, while competent patients have the right to refuse unwanted treatment, states are not constitutionally prohibited from enacting laws mandating continued

treatment to incapacitated patients when there is no "clear and convincing" evidence, such as a living will, to document that the patient would refuse life-sustaining care or treatment. Thus, states are not required to follow undocumented dictates from family members acting in the name of an incapacitated patient.

Following the *Cruzan* decision, undesignated family members may not always serve as healthcare proxies. *Cruzan* did not address the issue of whether a state would be compelled to defer to the decision of a surrogate where substantial evidence exists indicating that this would reflect the patient's wishes. However, the decision supports the view that incapacitated patients who have previously prepared a written document addressing their treatment choices and naming a healthcare decision maker are more likely to have their instructions implemented than those without such a document. (In some states, courts have accepted oral statements as compelling evidence of patient desires.)

The *Cruzan* decision and its progeny have encouraged patients of sound mind to write advance directives prior to any decline in mental capacity. It is in both the dentist's and the patient's interest to encourage the preparation of such advance directives, whereby important decisions are made and preferences discussed early in the relationship, prior to patient incapacity.

When the treatment relationship begins subsequent to incapacity, contact the patient's previous treating dentist and/or physician to discuss any advance directive arrangements the patient may have implemented during previous treatment. Obtain copies of any documentation he or she has of those arrangements, and make notes of these discussions in your own patient healthcare information records. If no advance directives exist, discuss with the patient and the patient's family members the need to pursue designation of a healthcare decision maker.

For more information call Dentist's Advantage at 888-778-3981, or navigate to the Dentist's Advantage website Risk Management section.

In addition to this publication, CNA and Dentist's Advantage have produced additional risk control resources on topics relevant to dental professionals, including: newsletters; articles; forms; letters; and claim scenarios.

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