AUSTRALIAN DENTAL ASSOCIATION

ADA Guidelines for Consent for Care in Dentistry

Document version: 2020-08-21

Clinical context

In order to practise in a professionally responsible manner, dentists must assist patients to make well informed decisions about treatment procedures. The requirements of meeting both the legal and professional practice requirements of consent for treatment are complex.

Key Requirements

The requirements of meeting both the legal and professional practice requirements of consent for treatment are:

(a) The patient must be legally capable of granting consent. If they are unable to do so, a substitute decision maker must have the legal authority to make the decision on behalf of the patient.

(b) The Patient must give their consent voluntarily, without duress.

(c) They must be able to understand the nature of the treatment proposed and the advice being given to them.

(d) The consent must be based on sufficient information about the treatment and its risks and benefits. This information must be appropriate to the circumstances of each patient. Patients must be warned of material risks. For complex procedures, written patient information sheets may be of value. Providing only written information is not satisfactory.

(e) Consent may be given in writing, orally or by conduct. In most routine dental examinations and treatments the patient's consent is obtained verbally. However, where the proposed treatment involves complex or invasive procedures, anaesthesia or sedation, significant expense and/or is of an elective or cosmetic nature, good professional practice warrants the use of a signed written consent form to document the process of consent and confirming the patient's agreement to the proposed treatment. A signed consent form does not, by itself, provide conclusive proof of a legally valid consent. Evidence of the dentist's usual practice supported by appropriate practice records may be required.

These Guidelines will assists members to comply with these requirements.

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1. Form of consent

Consent may be given in writing, orally or by conduct. In most routine dental examinations and treatments, the patient's consent is obtained verbally. However, where the proposed treatment involves complex or invasive procedures, anaesthesia or sedation, significant expense and/or is of an elective or cosmetic nature, good professional practice warrants the use of a signed written consent form to document the process of consent and confirming the patient's agreement to the proposed treatment.

By the action of consulting a dentist a patient's consent for initial examination is implied.

However, no further service should be provided without the express consent of the patient.

Oral consent is sufficient for most dental treatment; but for major treatment, either in terms of invasiveness or expense, a written consent form acknowledging that the nature, implications and risks of the proposed procedure have been explained, may provide useful evidence that the information was given and consent granted.

Patient information sheets and consent forms are a recommended useful tool where express written consent is required. However, for consent to be valid, despite a signature, the patient must understand what it is to which he or she is consenting. Evidence of the dentist's usual practice, supported by appropriate practice records may also be required.

2. Information to be provided

2.1 Warning of material risks

The High Court of Australia in *Rogers v Whitaker (1992) 175 CLR 479* and *Rosenberg v Percival (2001) 205 CLR 434* has held that in providing information to patients for the purposes of obtaining consent there is a duty to warn of a material risk inherent in a proposed treatment. Material risks are those that, in the particular circumstances, would significantly influence the likelihood of a "reasonable person in the patient's position" consenting to the proposed treatment. In considering whether a risk is a material one, the dentist must give consideration to the particular circumstances of the particular patient.

2.2 Information to be provided

The patient must be able to understand the nature of the materials and treatment proposed and the advice being given to them.

The consent must be based on sufficient information about the treatment and its risks and benefits. This information must be appropriate to the circumstances of each patient. Patients must be warned of material risks. For complex procedures, written patient information sheets may be of value. Providing only written information is not satisfactory.

(a) Patients are entitled to make their own decisions and should be given adequate information on which to base those decisions. Before asking for a patient or client's consent to treatment the dentist should:

(i) provide information presented in a way that the particular patient can understand, which may include written information or diagrams in addition to talking with the patient. Use plain non-technical language to communicate information to patients;

(ii) assure themselves that the patient has understood the information about the proposed procedure/treatment;

(iii) allow adequate time for the patient to reflect on information provided and respond. Encourage the patient to reflect, ask questions and consult with others;

(iv) ensure, wherever practicable, that the process is appropriate to the specific language, cultural and communication needs of patients, and be aware how these needs affect understanding. Where required, use a skilled and qualified language or cultural interpreter to help you meet patients' or clients' communication needs, preferably one recognised as competent in the particular context. Information about government-funded interpreter services is available on the Australian Government Department of Immigration and Citizenship website at www.immi.gov.au; and

(v) provide the patient with information requested by the patient.

(b) In determining what information to provide to a patient, a dentist should have regard to the following:

(i) the nature of the condition and its prognosis;

(ii) the nature of the proposed treatment - the proposed approach to the investigation, diagnosis and treatment;

(iii) other options for investigation, diagnosis and treatment;

(iv) the degree of uncertainty of any diagnosis arrived at;

(v) the degree of uncertainty about the therapeutic outcome;

(vi) the likely consequences of not choosing the proposed treatment;

(vii) the likelihood and nature of any adverse outcomes from the procedure/treatment;

(viii) the overall health and other circumstances of the patient;

(ix) the known or likely wishes of the patient;

(x) the maturity and cognitive capacity of the patient;

(xi) any significant long term physical, emotional, mental, social, sexual, or other outcome which may be associated with a proposed intervention; and

(xii) information about risks of any treatment, especially those that are likely to influence the particular patient's decisions. Known risks should be disclosed when an adverse event is common even though the detriment is slight, or when an adverse outcome is severe even though its occurrence is rare.

2.3 **Therapeutic privilege**

Therapeutic Privilege is a limited legally accepted circumstance for not disclosing specific clinical information to a patient, on the grounds that the information is likely to have a significant counter-therapeutic effect on the patient.

Withholding information under therapeutic privilege may only be applied in rare and exceptional circumstances.

3. Legal capacity

(a) Dentists must obtain the consent of a person with the legal capacity to provide the consent before dental procedures can be undertaken. Persons who usually do not have the capacity to understand the implications of having treatment are:

(i) young children (also known as minors);

(i) people with an illness, condition or disability affecting their ability to understand the information, make an informed decision and/or participate in the process of consent (e.g. people with dementia, Alzheimer's, people with some forms of mental illness and people with some forms of developmental or other disability); and

(ii) people under the influence of alcohol and/or other drugs.

(b) If a patient is unable to consent, other persons may be authorised by law to give consent on the patient's behalf.

(c) Authorisation by law may arise from:

(i) Guardianship legislation, such as the Guardianship 1987 (NSW) (for persons aged 16 years and over);

(ii) specific statutes e.g.: Consent to Medical Treatment and Palliative Care Act 1995 (SA);

(iii) legislation governing treatment or protection of children e.g.: the Minors (Property and Contracts) Act 1970 (NSW);

(iv) the appointment of a person as the legal guardian of a child;

(v) a valid Enduring Power of Attorney;

(vi) a valid Advance Care Directive by the patient; or

(vii) an order of a Court or Guardianship Tribunal.

3.1 Minors

(a) In the case of young children, dentists must obtain the consent of the child's parent or legal guardian for the dental procedure.

(b) The parent or guardian's consent must be given on the basis of the same information as would normally be required if consent were being obtained from an adult.

(c) The age at which a minor can consent to medical and dental treatment does differ depending on the jurisdiction.

(d) For example, under section 49 of the Minors (Property and Contracts) Act 1970 (NSW) *"where medical treatment or dental treatment of a minor aged less than 16 years is carried out with the prior consent of a parent or guardian of the person of the minor, the consent has effect in relation to a claim by the minor for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, the minor were aged 21 years or upwards and had authorised the giving of the consent.*

Where medical treatment or dental treatment of a minor aged 14 years or upwards is carried out with the prior consent of the minor, his or her consent has effect in relation to a claim by him or her for assault or battery in respect of anything done in the course of that treatment as if, at the time when the consent is given, he or she were aged 21 years or upwards."

"Dental treatment" is defined as:

(i) *"treatment by a dentist in the course of the practice of dentistry; or*

(ii) *treatment by any person pursuant to directions given in the course of the practice of dentistry by a dentist."*

(e) In South Australia, in the absence of consent by a parent or guardian, dentists must comply with the *Consent to Medical Treatment and Palliative Care Act 1995 (SA).* Under section 12 of that Act a medical practitioner may administer medical treatment to a child with the child's consent, if:

(i) the parent or guardian consents; or

(ii) the child consents and:

A. "the medical practitioner who it to administer the treatment is of the opinion that the child is capable of understanding the nature, consequences and risks of the treatment and the treatment is in the best interests of the child's health and well-being; and

B. the medical practitioner's opinion is supported by the written opinion of at least one other medical practitioner who has personally examined the child before the treatment is given."

Under that Act:

"Medical practitioner" is defined to mean "a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than a student) and includes a dentist."

"Medical treatment" is defined to mean "treatment or procedures administered or carried out by a medical practitioner in the course of medical or surgical practice by a dentist in the course of dental practice and includes the prescription or supply of drugs."

(f) For older children, at common law (in jurisdictions which do not have a statutory provision), a mature minor under the age of 16 can be competent to make personal dental treatment decisions when capable of fully understanding the treatment proposed.

(g) However, where the older child is living at home, it would be prudent to also obtain the consent of the parent for complex or major treatment, unless the older child specifically requests the dentist not to discuss the proposed treatment with their parent.

(h) If the consent of the parent is not being obtained, care should be taken to ensure that the person who will be billed for the treatment is also aware of the proposed treatment and agrees to meet the treatment expenses.

3.2 Consent by Court

Where a parent and child do not agree, the Court may intervene to make a decision in the best interests of the child or where there is otherwise a dispute in relation to consent. Dentists should seek legal advice as appropriate.

3.3 Illness or conditions affecting capacity to make decisions on treatment

(a) A patient with a mental illness, dementia or other condition or disability potentially affecting their ability to make informed decisions may consent to dental treatment where the dentist is satisfied that they are able to understand the proposed treatment, the information provided and the risks and benefits of treatment and are able to indicate their agreement to have the treatment.

(b) If there is doubt about the patient's ability to comprehend and/or make an informed decision, the dentist should obtain further clinical advice on the patient's capacity and/or seek the consent of a legally authorised substitute decision maker or apply for approval from an appropriate legal tribunal, body or court.

(c) In order to allow for necessary treatment to proceed for patients unable to make the decisions themselves, there is legislation in place in all jurisdictions to allow for substituted consent by a hierarchy of decision makers:

(i) The Guardianship Act 1987 (NSW);

(ii) The Medical Treatment Act 1988 (VIC);

(iii) The Powers of Attorney Act 1998 (QLD);

(iv) The Guardianship and Administration Act 1993 (SA);

(v) The Consent to Medical Treatment and Palliative Care Act 1995 (SA);

(vi) The Guardianship and Administration Act 1990 (WA);

(vii) The Guardianship and Administration Act 1995 (TAS);

(viii) The Powers of Attorney Act 1956 (ACT);

(ix) The Medical Treatment Act (Health Directions) Act 2006 (ACT); and

(x) The Adult Guardianship Act 1988 (NT).

For example, section 33A of the Guardianship Act 1987 (NSW) states as follows:

"33A Person responsible

(1) Object

The object of this section is to specify the person who is the person responsible for another person for the purposes of this Part.

(2) Person responsible for child

The person responsible for a child is the person having parental responsibility (within the meaning of the Children and Young Persons (Care and Protection) Act 1998) for the child. However, the person responsible is the Minister if the child is in the care of the Minister or the Director-General if the child is in the care of the Director-General.

(3) Person responsible for person in care of Director-General

The person responsible for a person in the care of the Director-General under section 13 is the Director-General.

(4) Person responsible for another person

There is a hierarchy of persons from whom the person responsible for a person other than a child or a person in the care of the Director-General under section 13 is to be ascertained. That hierarchy is, in descending order:

(a) the person's guardian, if any, but only if the order or instrument appointing the guardian provides for the guardian to exercise the function of giving consent to the carrying out of medical or dental treatment on the person,

(b) the spouse of the person, if any, if:

(i) the relationship between the person and the spouse is close and continuing, and

(ii) the spouse is not a person under guardianship,

(c) a person who has the care of the person,

(d) a close friend or relative of the person.

Note. Circumstances in which a person is to be regarded as having the care of another person are set out in section 3D. The meaning of close friend or relative is given in section 3E.

(5) Operation of hierarchy

If:

(a) a person who is, in accordance with the hierarchy referred to in subsection (4), the person responsible for a particular person declines in writing to exercise the functions under this Part of a person responsible, or

(b) a medical practitioner or other person qualified to give an expert opinion on the first person's condition certifies in writing that the person is not capable of carrying out those functions, the person next in the hierarchy is the person responsible for the particular person."

3.4 Enduring Powers of Attorney / Advanced Directives

(a) A general power of attorney is a mechanism for giving an agent authority to manage a person's financial and property affairs. It does not give the person appointed power to make health treatment decisions on behalf of the patient.

(b) However, in some jurisdictions, an enduring power of attorney may also enable the person nominated as the attorney to make health treatment decisions for the patient when the patient becomes incapable of doing so themselves. In other jurisdictions, some form of Advance Directive for substitute decision-making for lifestyle, accommodation or medical decisions is available.

(c) Such authority made pursuant to the relevant legislation made in one state or territory is legally recognised in the other Australian jurisdictions.

3.5 Medical emergencies and advanced care directives

The usual principles governing consent do not apply to emergency situations where immediate treatment is necessary in order to prevent a serious and imminent injury to a person's health.

In *Hunter and New England Area Health Service v A* [2009] NSWSC 761, Justice McDougall provided a summary of principles concerning the issue of consent in emergency care situations:

(1) except in the case of an emergency where it is not practicable to obtain consent (see at (5) below), it is at common law a battery to administer medical treatment to a person without the person's consent. There may be a qualification if the treatment is necessary to save the life of a viable unborn child.

(2) Consent may be express or, in some cases, implied; and whether a person consents to medical treatment is a question of fact in each case.

(3) Consent to medical treatment may be given:

by the person concerned, if that person is a capable adult;

by the person's guardian (under an instrument of appointment of enduring guardian, if in effect; or by a guardian appointed by the Guardianship Tribunal or a court);

by the spouse of the person, if the relationship between the person and the spouse is close and continuing and the spouse is not under guardianship; by a person who has the care of the person; or

by a close friend or relative of the person.

(4) At common law, next of kin cannot give consent on behalf of the person. However, if they fall into one or other of the categories just listed (and of course they would fall into at least the last) they may do so under the Guardianship Act.

(5) Emergency medical treatment that is reasonably necessary in the particular case may be administered to a person without the person's consent if the person's condition is such that it is not possible to obtain his or her consent, and it is not practicable to obtain the consent of someone else authorised to give it, and if the person has not signified that he or she does not wish the treatment, or treatment of that kind, to be carried out.

(6) A person may make an "advance care directive": a statement that the person does not wish to receive medical treatment, or medical treatment of specified kinds. If an advance care directive is made by a capable adult, and is clear and unambiguous, and extends to the situation at hand, it must be respected. It would be a battery to administer medical treatment to the person of a kind prohibited by the advance care directive. Again, there may be a qualification if the treatment is necessary to save the life of a viable unborn child.

(7) *There is a presumption that an adult is capable of deciding whether to consent to or to refuse medical treatment. However, the presumption is rebuttable. In considering the question of capacity, it is necessary to take into account both the importance of the decision and the ability of the individual to receive, retain and process information given to him or her that bears on the decision.*

(8) If there is genuine and reasonable doubt as to the validity of an advance care directive, or as to whether it applies in the situation at hand, a hospital or medical practitioner should apply promptly to the court for its aid. The hospital or medical practitioner is justified in acting in accordance with the court's determination as to the validity and operation of the advance care directive.

(9) Where there is genuine and reasonable doubt as to the validity or operation of an advance care directive, and the hospital or medical practitioner applies promptly to the court for relief, the hospital or practitioner is justified, by the emergency principle, in administering the treatment in question until the court gives its decision.

(10) It is not necessary, for there to be a valid advance care directive, that the person giving it should have been informed of the consequences of deciding, in advance, to refuse specified kinds of medical treatment. Nor does it matter that the person's decision is based on religious, social or moral grounds rather than upon (for example) some balancing of risk and benefit. Indeed, it does not matter if the decision seems to be unsupported by any discernible reason, as long as it was made voluntarily, and in the absence of any vitiating factor such as misrepresentation, by a capable adult.

(11) What appears to be a valid consent given by a capable adult may be ineffective if it does not represent the independent exercise of persons volition: if, by some means, the person's will has been overborne or the decision is the result of undue influence, or of some other vitiating circumstance.

I have spoken above in terms of medical treatment, and hospitals and medical practitioners. However, the principles apply more broadly: to all those (including ambulance officers and paramedics) who administer medical treatment. They extend further to other forms of treatment (for example, dental treatment) where, without consent, the treatment would constitute a battery.

4. Consent must be voluntary

4.1 Absence of coercion

It is important that:

(a) consent is voluntarily given without duress by the dentist or another person (such as a family member);

(b) ample time is allowed for decision-making.

A legally capable patient may refuse or withdraw their consent at any stage, even though such treatment is aimed to be in the best interests of the patient and failure to have it may be harmful to the patient.

5. Possible consequences of not obtaining consent for treatment

Dentists must obtain the consent of a patient before providing treatment to that patient. Failure to obtain consent can give rise to any one or more of the following:

1. a cause of action against the dentist in assault or battery;

2. a negligence claim; or

3. a complaint of professional misconduct.

5.1 Battery

Battery is the negligent, reckless or intentional touching of another person (other than that which is generally acceptable in the ordinary conduct of daily life) without consent, lawful excuse or justification.

Assault and battery is a criminal offence which involves both the threat and actual affliction of personal violence.

Criminal offences can lead to penalties and in some cases imprisonment.

In addition to the criminal offence, battery can also result in a civil claim in tort in the form of trespass to the person.

Trespass to the person is the infringement of a person's rights in relation to his or her body by direct interference of another without lawful justification. The interference may be intentional or negligent. There are three forms of trespass to the person, assault, battery and false imprisonment.

Civil cases can lead to a claim for damages.

In most cases, dentists only treat patients who willingly submit to treatment and therefore a claim in battery is rare.

A more likely legal consequence is an allegation of negligence asserting that the dentist failed to adequately inform the patient of the material risks associated with the procedure.

5.2 Negligence

A claim for negligence can arise in relation to a breach of a duty of care in relation to the treatment of a patient as well as a failure to warn a patient of material risks associated with that treatment.

(a) Duty of care

The duty of care and standard of care for health professionals has now been codified in civil liability legislation in Australia.

For the purposes of these Guidelines, we refer to the *Civil Liability Act 2002 (NSW),* however, there is similar legislation in other States and Territories of Australia.

A person is not negligent in failing to take precautions against a risk of harm unless:

(i) the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known); and

(ii) the risk was not insignificant; and

(iii) in the circumstances, a reasonable person in the person's position would have taken those precautions.

In determining whether a reasonable person would have taken precautions against a risk of harm, the court is to consider the following (amongst other relevant things):

(i) the probability that the harm would occur if care were not taken;

(ii) the likely seriousness of the harm;

(iii) the burden of taking precautions to avoid the risk of harm;

(iv) the social utility of the activity that creates the risk of harm.[1]

(b) Causation

A determination that negligence caused particular harm comprises the following elements:

(a) that the negligence was a necessary condition of the occurrence of the harm (factual causation); and

(b) that it is appropriate for the scope of the negligent person's liability to extend to the harm so caused (scope of liability).[2]

(c) Onus of proof

In proceedings relating to liability for negligence, the plaintiff (claimant) bears the onus of proving, on the balance of probabilities, any fact to the issue of causation.[3]

(d) Standard of care for professionals

A person practising a profession (a professional) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.

However, peer professional opinion cannot be relied on for the purposes of this obligation if the court considers that the opinion is irrational.

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[1] Civil Liability Act 2002 (NSW), section 5B
[2] Ibid, section 5D
[3] Ibid, section 5E

The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this obligation.

Peer professional opinion does not have to be universally accepted to be considered widely accepted.[4]

The above standard of care for professionals does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death or injury to a person associated with the provision by professional or a professional service. This is dealt with below.

(e) Duty to warn of risks

The High Court of Australia in *Rogers v Whitaker (1992)* and *Rosenberg v Percival (2001)* has held that in providing information to patients for the purposes of obtaining consent there is a duty to warn of a material risk inherent in a proposed treatment.

Material risks are those that, in the particular circumstances, would significantly influence the likelihood of a "reasonable person in the patient's position" consenting to the proposed treatment. In considering whether a risk is a material one, the dentist must give consideration to the particular circumstances of the particular patient.

Therefore, a failure to provide sufficient information about the procedure and associated risks may amount to negligence.

Amongst other matters, for an action in negligence to succeed in a failure to warn case, the following must be established:

(i) that in the particular circumstances the person would have placed significance upon the risk and would have refused treatment because of that identified risk; and

(ii) that the specific risk did arise and the person suffered the actual harm identified.

The test of what should have been disclosed to the patient is a subjective one, based on the particular circumstances of that patient, and not simply what information most dentists would have provided for that procedure or treatment.

5.3 Review of professional conduct

Health care practitioners are regulated under the *Health Practitioner Regulation National Law*. Legislation has been passed in each state and territory of Australia. The legislation has similarities and differences. As the Queensland Act is the model standard, these Guidelines refer to the *Health Practitioner Regulation National Law Act 2009 (Qld).*

National Law

Under the National Law, "unsatisfactory professional performance", of a registered health practitioner, means *"the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the health profession in which the practitioner is registered is below the standard reasonably expected of a health practitioner of an equivalent level of training or experience"*. [5]

"Unprofessional conduct", of a registered health practitioner, means *"professional conduct that is of a lesser*

[4] Ibid, section 5O
[5] Health Practitioner Regulation National Law Act 2009 (Qld), section 5, definition of "unsatisfactory professional performance".

standard than that which might reasonably be expected of the health practitioner by the public or the practitioner's professional peers…"

Engaging in "unsatisfactory professional performance" or "unprofessional conduct" can lead to an investigation and in some cases loss of professional registration.

5.4 Code of Conduct for Registered Health Practitioners

The Code of Conduct for Registered Health Practitioners is indicative of the standard expected by health practitioners with respect to consent. [6]

5.5 Funding conditions

Providing health care services without adequate consent can also be over-servicing or inappropriate prescribing of medications or provision of diagnostic imaging services which may infringe funding conditions associated with (as relevant) Medicare payments, PBS payments and payments by private health insurers. Infringement of laws relating to Medicare and PBS payments can incur significant penalties.

6. Practical considerations for dentists

6.1 Quality of communication

(a) Good communication lies at the heart of successful dentist/patient relationships, whilst poor communication is likely to engender apprehension, dissatisfaction, suspicion and possible litigation. Good communication skill has many aspects. Practitioners may require improved ability in listening and feedback techniques, avoidance of technical language, or understanding of negotiation, decision-making, behavioural processes and the needs of minority groups.

(b) The effect of time spent on communication is less dependent on its quantity than its quality. Thus commitment to providing patients with ample information for consent will not necessarily increase the cost of treatment, particularly if improvements in treatment efficiency or reductions in stress and anxiety for the patient follow better communication.

(c) Patients are less likely to sue health practitioners if they were provided sufficient information and there are no "surprises".

(d) In explaining the nature of proposed treatment, communication can effectively be extended by use of diagrams, suitable pamphlets and other literature, photographs, videos and models. The cost of a proposed treatment plan is always an important aspect to be communicated.

6.2 Determining reasonable disclosure

(a) Whilst the extent of information which should be given to patients will depend on the circumstances of each case, the courts have provided some guidance.

(b) Matters are material if they 'might influence the decisions of a reasonable person in the situation of the patient'. If, for example, a risk involves potential harm or injury so slight, or so unlikely to occur, that no reasonable person would be influenced by it, then that risk need not be discussed.

(c) Disclosure, however, should not be based upon a hypothetical 'reasonable person' but on the circumstances and understanding of the particular patient in question to whom a risk may have great significance.

[6] :Code of conduct for registered health practitioners" Dental Board of Australia, page 5

(d) Relevant factors, especially in relation to risk, might include:

(i) The nature of treatment

A. More complex treatment requires more information. There is clearly a difference between orthognathic surgery and plaque removal.

B. Most procedures carried out in general practice would be considered minor. However, an extensive treatment plan composed of numerous minor items will require elaboration, as will more costly or controversial items.

(ii) The magnitude and/or likelihood of possible harm

Information about the possibility of serious harm should normally be given even if the chance of it occurring is slight. Similarly, information should generally be given if the potential harm is relatively slight but the risk of it occurring is great. Typical risks in general dentistry which may need to be mentioned include the possibility of nerve damage in oral surgery procedures, perforation or instrument breakage in endodontics, and crown and bridge failures. It may not be necessary to discuss risks that are inherent in any operation, such as post-operative infection unless the patient raises a particular concern.

(e) The personality, temperament and attitude of the patient

The provision of information should be viewed as a shared decision making. More information must be given to those keen to have it for more than just reassurance, especially in response to specific questions. On the other hand, in situations where the patient does not wish to participate in the decision making, the dentist should give the patient the appropriate essential information about the dental condition, proposed treatments and risks involved. The dentist must be satisfied that the patient understands their right to receive information and has freely decided not to require or ask for more information.

(f) The patient's level of understanding

In determining what information is required, the dentist must be satisfied that the patient is able to understand the information and that their consent to the proposed treatment is being sought. If there is doubt about this, a more detailed assessment will be required. Effective communication involves a dialogue about the proposed treatment and its attendant risks. Seeking feedback from the patient may give an indication of his/her comprehension.

6.3 Maintaining a record of consent being given and consent forms

(a) Dentists should make a sufficiently detailed note of consent discussions in the patient's medical records, including particular advice or information provided the consent obtained. To supplement the record, a consent form may be used.

(b) In all situations, it is necessary to keep careful, clear records. Disclosure of information and subsequent oral consent (which suffices for the vast majority of dental procedures) should be listed in the clinical notes.

(c) For major treatment, either in terms of invasiveness or expense, written consent forms acknowledging that the nature, implications and risks of the proposed procedure have been explained may provide substantial, although still not entirely conclusive, evidence that information was given and consent granted. Whenever in doubt about whether a procedure is major or minor, written consent should be obtained. An appropriate alternative may be to have adequately written records of the information given, shown to and initialled by the patient. The signed consent form, whilst a useful tool, is not conclusive.

(d) Consent forms should clearly identify the patient. They should contain the patient's name, date of birth and

if a legally authorised substitute decision maker is giving consent, the name and the legal status of their authority to consent on behalf of the patient, and specify the procedure to which the patient is consenting.

6.4 Potential controversies

(a) Dentists must take care always to mention any proposed use of treatments which, although considered standard, safe and minor procedures by the dental profession, might be regarded with some doubt by certain patients (for example, X-rays or amalgam fillings), so that these patients have the opportunity to request further information or decline such treatment modalities.

(b) Procedures which have yet to receive general acceptance as standard or desirable practices, or which do not accord with mainstream dental opinion, necessitate the precaution in every case of ensuring that 'fully informed' consent is forthcoming.

(c) Consent to participate in health and medical research is a separate consent to medical treatment and should be obtained.

6.5 Less tangible items of treatment

Genuine service should be free from any suspicion of over servicing. Consent for relatively minor procedures which might not be very apparent after completion, such as occlusal adjustment, recontouring of existing restorations or fissure sealants, especially if numerous, will often require fuller justification than more obvious items.

6.6 Situations in which authority is not clear

If a practitioner cannot be certain that consent is valid: for example, where there is conflict between parent and child, or where a child or other legally incompetent person is under the control of a person not normally authorised to give consent; then it would be unwise to proceed with treatment (except in the case of an emergency) until the situation is clarified.

6.7 Treatment alternatives

(a) Where alternative treatments have been expounded, a dentist should accept the patient's preferred option within reason. For instance, few dentists would have problems about providing a partial denture rather than a bridge, or a complex amalgam rather than a full crown on the basis of the patient's informed decision. But it is usually better to decline giving a treatment of the patient's choice which, although included among discussed options, has been recommended against or declared undesirable: for example, the provision of an immediate full denture rather than a recommended course of relatively simple conservative work. In the event of problems, it is preferable not to have acted contrary to one's own recommendation.

(b) If any part of an accepted treatment plan is to be delivered by someone other than the dentist presenting it, such as another dentist or auxiliary within the practice, then the patient must be made aware of this in advance.

7. Other types of consent

These Guidelines only deal with consent to dental treatment. There are other types of consent which may be required to be requested from the patient. These include:

(a) Privacy consent in relation to the collection, use and disclosure of their personal information;

(b) Financial consent;

(c) Consent to medical treatment;

(d) Consent to participate in research projects; and

(e) Consent to the retention and use of biological samples for research.

8. Reference materials

The Dental Board of Australia has endorsed the Code of Conduct for Registered Health Practitioners, prepared by the Australian Health Practitioner Regulation Agency, which sets out key elements of good practice in obtaining patient consent to treatment. The Code recommends the National Health and Medical Research Council (NHMRC) Clinical Practice Guidelines on Providing Information to Patients (www.nhmrc.gov.au) as a useful resource for dentists. These documents have been considered in preparing this Policy and the Guidelines.

Dentists should read and familiarise themselves with these materials.

9. Disclaimer

These Guidelines only provide a summary of general information and should not be relied upon as legal advice. The subject of consent is constantly under review by the legislature and courts. These guidelines have attempted to express views consistent with the law as at the date of their publication.

Related resources

ADA Policy Statement 5.17 – Dental Records

Contribute to the development of ADA guidance to the profession

This Guideline has been developed by ADA expert committees. Feedback from the profession is welcome and may be submitted to contact@ada.org.au for consideration in future guideline development.