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Informed consent in dentistry in the UK: and some common factors affecting it

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Dissertation submitted to Fernando Pessoa University

As part of the requirements for obtaining

the Master's Degree in Oral Medicine

Farhad Danishmal

Abstract

Obtaining informed consent is a legal requirement in practice of dentistry which begins at the first visit of any patient, when treatment is being considered, and continues until the end of care. However, there are some practitioner, patient and guideline related factors that affect obtaining a proper consent. This study aims to review the available literature regarding the informed consent in dentistry in the UK and focuses on the common factors mentioned above.

Keywords: Informed Consent; Dentistry in the UK; Health Literacy; Communication; Ethics

Resumo

Obter consentimento informado é um requisito legal na prática de medicina dentária que começa na primeira consulta, na qual se delibera sobre o tratamento que irá ser realizado, e continua até ao fim de todas as consultas. No entanto, existem alguns fatores relacionados com o médico dentista, com o paciente, com a formação do profissional de saúde e com a literacia em saúde do paciente, que podem afetar a obtenção de um consentimento informado, livre e esclarecido que seja verdadeiramente adequado. Este estudo tem como objetivo fazer uma revisão da literatura em relação ao consentimento informado na prática de medicina dentária no Reino Unido, focalizando os fatores acima mencionados.

Palavras-chave: Consentimento Informado;Medicina Dentária no Reino Unido; Literacia em Saúde; Comunicação; Ética

Acknowledgement

Firstly, I would like to thank my tutor Professor Susana Teixeira for the guidance, encouragement and advice she has provided throughout my time as her student. I have been extremely lucky to have a tutor who cared so much about my work, responded to my questions and queries so promptly.

I would like to thank my father Abdul Haq Danishmal and mother Tahira Danishmal who have taught me lesson of honesty, humanity, love and respect to others. They have helped me throughout my life and have not let me feel any hardship no matter how tough time they have gone through.

I also would like to show my gratitude to my wife, Maryam Nizami, who has always been supportive and caring and stood side by side with me in every situation. She is not only a good wife but also a brilliant mother who looks after our daughter with great patience.

Lastly, a big thank to my one and only two-and-a-half-year-old daughter, Arya Danishmal, who has given me the energy and momentum to move on and finish the course. She is the apple of my eyes and relief to my heart.

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DH	Department of Health
GDC	General Dental council
MCA	Mental Capacity Act
NHS	National Health Service
TGG	Training Grade Group

1- Introduction

For centuries, the law has recognized a person's autonomy or right to self-determination through the concept of consent (*Bridgman,2006; Slater et al. 1767)*. Informed consent is the moral doctrine embracing those rights through full disclosure and understanding and under which patients are entitled to receive sufficient information in a way that they can understand any substantial risk or risks which may be special in kind or special to the patient, so that they can make a balanced judgment (Health Service Circular, 1999). The principle of Informed consent implies that a competent patient should be provided with sufficient information in a way that is understandable to him/her. Failing to provide informed consent can be considered negligence.

The guidance about consent in Dentistry in the UK is currently provided by the General Dental Council (GDC) and the Department of Health (DoH). The GDC gives advice about the information that patients ought to be given before they consent to treatment. The information should cover knowledge of the diagnosis, prognosis, and options for treatment (including no treatment); details about the procedure or treatment, its purpose, likely benefits and the "serious" and common complications that may occur.

Although the GDC advises doctors to tell patients about "serious or frequently occurring risks", there are no guidelines about specific complications that should be disclosed; the detail of risk is left to the discretion of the individual doctor who is responsible for gaining consent.

There are two types of consent, implied and expressed. Implied consent is obtained when a patient makes an appointment, presents for examination, and accepts the continuation of treatment. Expressed consent includes verbal (oral) consent and written consent. Verbal consent is adequate for routine treatment such as fillings and prophylaxis, only if full records are kept, and written consent is necessary in case of extensive intervention, procedures involving risks, and where general anaesthesia or sedation is used.

Competent adult patients have the legal right to withhold their consent to treatment, or to withdraw it at any point during treatment. This rule applies to all areas of treatment and care, even where treatment offered is for a serious or severe condition. Where a person cannot be considered competent, in England and Wales, another set of legal principles are affected, by the common law and now by statute of the Mental Capacity Act 2005 (Dougall and Fiske, 2008;

Fullbrook, 2007). The law in Scotland meets the needs of adults with incapacity through the Adults with Incapacity (Scotland) Act 2000 (Dougall and Fiske, 2008; Griffith, 2006).

The MCA affects people over 16 years of age with mental illness, dementia, learning disabilities, brain damage, confusion, drowsiness, loss of consciousness, delirium, or concussion. It also includes those who lack capacity because of alcohol or drug use (Dougall and Fiske, 2008).

For the purpose of the MCA, 'a person lacks capacity in relation to a specific matter if at the material time (s)he is unable to make a decision for her/himself in relation to the matter, because of an impairment of, or a disturbance in, the functioning of the mind or brain (The Mental Capacity Act 2005). A person is considered unable to make a decision if they cannot:

- Understand information relevant to the decision to be made
- Retain that information in their mind
- Use or weigh up that information, or
- Communicate their decision.

If having followed all of the above stages, the person is considered to lack capacity, a decision can be made on their behalf. The MCA states that such a decision 'must be done, or made in her/ his best interests' and it applies to everyone making decisions on that person's behalf, in relation to all aspects of financial, personal welfare and healthcare decision-making and actions (Dougall and Fiske, 2008).

The climate of change now being experienced by many professionals in the healthcare system means that for almost all medical treatment procedures 'implied consent' may offer limited defence when even minor procedures go wrong. The very nature of consent may prove to be problematic for many when moving from the conceptual to the practical, especially for the inexperienced. Some of the problems associated with the obtaining of consent have been stated to be: (Cannavina et al, 2000; Hutchinson, 1998; Mulcahy et al, 1997; Rowe, 1994)

- Lack of relevant knowledge on the part of the health professional
- The amount of information to be given to the patient in a specific situation
- Level of understanding on the part of the patient
- Ability of the patient to comprehend the information given to them.

The aim of this article is to focus on the available literature regarding informed consent in the UK in Dentistry and some of the practitioner, patient and guideline elements impacting it.

1.1- MATERIALS AND METHODS

Search Strategies: Pub Med, Medline, B-on, EMBASE, PsycINFO, Cochrane Library, PSYNDEX, Scopus, SciELO, Web of Science and BDJ databases were electronically searched for articles published from 2000 to 2017.

The following keywords were used jointly or individually:
Informed Consent; Dentistry in the UK; Health Literacy; Communication; Ethics

Exclusion criteria: articles published in languages other than English, studies in which the main topics were not related to informed consent in dentistry in the UK, or were related to informed consent for children, full text articles that were not available on the database, single case report, duplicated articles, and commentaries.
The initial search resulted in a list of 1739 articles. In turn, titles were analyzed and based on exclusion criteria only 25 abstracts were included. After reading of the available abstracts, 9 articles were included in the study.

2-Development -results of the literature review

2.1-Practitioner related factors

In 2000, the publication of the National Health Service (NHS) plan recognised the importance of each patient's right to be able to give informed consent (Chate, 2008; Department of Health, 2000) and in the same year, the British Dental Association issued a comprehensive advice sheet on consent (Chate, 2008; British Dental Association, 2000). A year later the Department of Health published a guide to consent for the examination or treatment of a patient (Chate, 2008; Department of Health, 2001a) together with guidance on its implementation (Chate, 2008; Department of Health, 2001b) as well as the key legal points of consent as it pertains to clinical

practice in England (Chate, 2008; Department of Health, 2001c). These same principles and guidance were then published in a suitably modified form for practice in Northern Ireland two years later (Chate, 2008; Department of Health and Social Services and Public Safety, 2003a, b). All of them are based on case law and are meant to provide clinicians with unequivocal guidance as to how valid consent can be gained from those patients who are capable of giving it, as well as how treatment may be lawfully delivered to those who are not, both of which are mandatory legal requirements (Chate, 2008; Department of Health, 2001a).Yet a proportion of healthcare professionals have either not read or cannot reliably recall these guidelines, so much so that the full legalities of obtaining valid consent are incompletely understood by most medical staff (Chate, 2008; Chadha and Repanos, 2004). Equally, there is reportedly some evidence that dentists may not always understand the process of consent nor when it should be applied, (Chate, 2008; Milan, 2007). For example, in June 2007, a questionnaire, which can be seen in Appendix 1, was circulated to 216 consultant orthodontists and 207 TGG (training grade group) orthodontists in England, Wales and Northern Ireland, using an address list supplied by the BOS. Only 179 of them answered the questionnaire. Out of the 21 answers to the 11 questions that were posed, on average they correctly provided only 12 of them (57%), and yet to fulfil their ethical obligation and legal requirement of being in a position to gain valid consent, the only acceptable 'audit' standard would have been for all of them to have been answered correctly. In this respect, the only question where this was achieved was in the first answer to question one, namely that for a patient to be able to consent to a course of treatment, the clinician must explain to them the risks and benefits of the proposed treatment (Chate, 2008).

As a sample, the below tables show the number and percentage of consultant orthodontists who answered to three questions of the questionnaire:

Table 1 **The number and percentage of the 179 consultant orthodontists who answered the first question correctly**

Answer	Number of consultants	Percentage
The risks and benefits of the proposed treatment	179	100%
The risks and benefits of any alternative treatments	108	60%
The consequences of remaining untreated	54	30%

Reference source: (Chate, 2008).

Table 2 **The number and percentage of the 179 consultant orthodontists who answered the second question correctly**		
Answer	Number of consultants	Percentage
The information about the proposed treatment is both understood and retained	172	96%
The patient can use and weigh this information in the decision making process	36	20%
Reference source: (Chate, 2008).		

Table 3 **The number and percentage of the 179 consultant orthodontists who answered the third question correctly**		
Answer	Number of consultants	Percentage
Ascertain whether any advance directives were made by the patient if and when they were previously competent	17	10%
Involve the carers and relatives in the discussion process	112	63%
Seek a second professional opinion	70	39%
Only carry out treatment deemed to be in the patient's best interest	90	50%
Reference sources: (Chate, 2008).		

Another research found that the form in use in General Dental Services which requires a patient's signature is mistakenly regarded as a consent form by two thirds of dental practitioners (King, 2001; King, 2000).

It is likely that a similar situation exists among other dental professionals and so these findings provide an opportunity for all clinicians to improve their education and therefore their ability to comply with both their ethical obligation and legal requirement to gain valid consent from patients before they start treatment (Chate, 2008).

2.2-Patient related factors

A number of factors can affect a person's ability to provide consent, even when they have the capacity to do so. There are also circumstances where, unless correct measures are taken, capacity cannot be properly assessed and may not, therefore, be evident (Dougall and Fiske, 2008).

Literacy, dyslexia, learning disability and hearing impairment will be considered in this context.

2.2.1-Literacy

The ability to read is a prerequisite to understanding information provided in written format. Literacy, which is defined as the 'use of printed and written information enough to function in society', may not be as high as we imagine. The 1992 US National Literacy Survey found that a fifth of adult Americans were functionally illiterate, reading at or below the level of a 10-year-old child, and would have difficulty in understanding healthcare information, including consent forms (Dougall and Fiske, 2008; Kirsch et al., 1999). Another quarter was only marginally literate. Whilst there are currently no similar surveys in the UK, it is known that around seven million people in the UK have literacy, numeracy and language skill needs (Dougall and Fiske, 2008; The Patient's Network, 2003). There is still a stigma attached to poor literacy and people may prefer not to disclose this information. There is even an example of a person pretending to have a visual impairment (a disability which results in sympathy and offers of help) rather than disclosing a literacy problem. However, lack of disclosure prevents people being offered the help and support they need (Dougall and Fiske, 2008; French, 1994).

As the impact that health literacy can have on health is realised, it is climbing the healthcare agenda. The Kirsch study13 in 1999 found:

- 33% of English-speaking hospital patients could not read or understand basic health materials
- 42% could not understand instructions to take medication on an empty stomach
- 25% did not understand information on an appointment slip, and
- 60% did not understand a standard consent form.

Health literacy relates to how well someone can read or comprehend health information (delivered in written, oral or visual format) and then act on this information (Dougall and Fiske, 2008; Kempner, (2003). It has cultural, language and educational components. Low health literacy can seriously limit a patient's ability to prevent or manage disease (Dougall and Fiske, 2008; Williams et al. 1998). For example, people with low health literacy are more likely to make medication or treatment errors, become hospitalised (Dougall and Fiske, 2008; Baker et al. 1998) and have problems negotiating healthcare systems. Older people and those in poor overall health have the worst health literacy. Research in this area suggests that patients retain as little as 12% of explanations, creating significant health risks (Dougall and Fiske, 2008; Kirsch et al., 1999; French, 1994), and this highlights the gap between what patients actually understand and

what healthcare professionals expect them to know. When developing written oral health information material, it is appropriate to consider the reading ability of the group(s) it is aimed at and tailor the information to suit the literacy skills of patients and carers in that group ((Dougall and Fiske, 2008; Hoffman and McKenna, 2006).

2.2.2-Language

In considering language it is important to bear in mind both fluency and literacy. Some ethnic groups, or members of ethnic groups, will be fluent in English whilst others will not, and there may be a gender bias. For example, according to the Fourth National Survey of Ethnic Minorities, English was spoken by 75% of Bangladeshi men but only 4% of women aged 45 to 64 years. Although English language skills improve in the younger generations, only around 30% of Bangladeshi women in the 25 – 44year age group were fluent in English, compared with nearly 80% in 16-24 year old women (Dougall and Fiske, 2008; Modood et al., 1997). Where fluency is poor, interpreter services may be required to establish understanding and facilitate gaining consent. Good fluency does not necessarily extend to good literacy, and a person who is able to communicate well in a language may not be able to read that language well enough to understand information leaflets or consent forms. Literacy levels in some ethnic groups are low, for example, a level as low as 16% has been reported in the Bangladeshi community (Dougall and Fiske, 2008; Dustman and Fabbri, 2003). Where there is good literacy, the individual should be provided with information sheets in their language of choice. Where there is poor literacy, it may be necessary to rely on interpreter services. In a recent study of young Bangladeshi adults with a learning disability, 88.5% spoke English and chose to do the survey in English (Dougall and Fiske, 2008; Doshi, 2007). Despite this situation, one of the study participants who spoke English commented that: '[I have] never been to the dentist, [I would] like to go, but need someone to come with me... and I would [go if] someone make me appointments, as my parents don't speak English. So, I can't go.' Somewhat paradoxically, his parents lack of fluency in English impacted on his dental attendance (Dougall and Fiske, 2008).

2.2.3-Dyslexia

Dyslexia is a common condition, affecting one in ten of the population that can impact on understanding. Following the Paterson ruling in 2007, it is recognized as a disability at all levels of the condition (Dougall and Fiske, 2008; Gibb, F. (2007). This specific learning difficulty is characterized by difficulties in processing word-sounds and by weakness in short-term verbal memory (Dougall and Fiske, 2008; Dyslexia Action website. 2008). It is not related to intelligence, race or social background, and may affect up to 10% of your patients and your staff (Dougall and Fiske, 2008; British Dyslexia Association website, 2008). These difficulties arise from inefficiencies in the language processing areas of the left hemisphere of the brain and appear to be linked to genetic differences (Dougall and Fiske, 2008; Dyslexia Association of Ireland). There is evidence that many people with dyslexia have strengths and abilities in tasks that involve creative and visual based thinking. People with dyslexia and literacy problems will remember as little as 10% of what they read and as little as 50% of what they hear. However, it is important to realise that they remember 90% of what they say as they do something (Dougall and Fiske, 2008; British Dyslexia Association website, 2008), thus questioning the suitability of the standard consent form for this group.

Dyslexia is usually a 'hidden disability' and often older and middle-aged individuals are themselves unaware that they have such difficulties (Dougall and Fiske, 2008; The Dyslexia Institute, 2005). Indeed, in a recent article looking at dyslexia in undergraduate and postgraduate dental students, 8% identified themselves as dyslexic, whilst psychometric testing identified 33% of the group as having scores suggesting the presence of dyslexia (Dougall and Fiske, 2008; Shirawi, 2007). Dyslexia is not the same as a problem with reading, and many people learn to read but continue to have difficulties with spelling, writing, memory and organisation. It often causes problems in arithmetic and recalling number related facts. The degree to which dyslexia causes problems in learning and everyday life depends on many factors, including its severity, the other strengths and abilities the person has and the kind of teaching and support that they have been given. For example, printing information on coloured paper makes it easier to read for some people with dyslexia. The colour depends on the individual, but black print on cream paper is the combination that suits most people. Some people use a coloured acetate overlay to achieve the same effect (Dougall and Fiske, 2008; British Dyslexia Association website, 2008). Research shows that early intervention is effective (Dougall and Fiske, 2008; Mathes and

Denton, 2002) and the key to success is through improving skills and developing positive compensatory and coping strategies (Dougall and Fiske, 2008; Illingworth, (2005). Any changes you make to accommodate people with dyslexia are good practice for everyone. When providing written information, bear in mind that font size and form are important. Fonts should be rounded to allow for space between the letters, with Arial and Trebuchet MS being preferred to Times New Roman. The latter contains confusing ticks and tails which can create difficulties (Dougall and Fiske, 2008).

2.2.4-Learning disability

Learning disability is a significant impairment of intelligence and social functioning acquired before adulthood (Dougall and Fiske, 2008; Mencap website, 2008). Its cause can be genetic, congenital or acquired (Dougall and Fiske, 2008; Fiske et al., 2007). People with learning disability, to varying degrees, have difficulties understanding, learning and remembering new things, and in generalizing learning to new situations. These difficulties with learning may lead to difficulties with social tasks, such as communication, self-care, awareness of health, and safety. They may also impact on capacity, the ability to make decisions and the ability to give informed consent. This group will need to have their capacity assessed before invasive or irreversible dental procedures are carried out. Implied or verbal consent will suffice for examinations and minimally invasive procedures where the individual is co-operative. There are no reliable statistics regarding the number of people with learning disabilities in the UK. Estimates suggest that there are between 230,000 and 350,000 people with severe learning disability and 580,000 to 1,750,000 with mild to moderate learning disability in the UK, (Dougall and Fiske, 2008; Northfield, 2004) and more than 29,000 people with a severe or profound learning disability live at home with a carer aged over 70 (Dougall and Fiske, 2008; *Strategy for learning disability for the 21st century*, 2001).

The commonest genetic causes of learning disability are Down's syndrome and Fragile X syndrome, with an incidence of around 1 in 700 and 1 in 4000 births respectively (Dougall and Fiske, 2008; Mencap website, 2008). Learning disability is common and every dental team will meet affected patients. The degree of learning disability impacts on how much a person can learn, and their ability to make decisions and to participate in daily living activities. Some people

with a mild learning disability do not need much support in their lives, whilst others may need support with many activities – from getting dressed and going shopping to filling out forms. A learning disability does not preclude someone from learning provided they get the right support. *The Government White Paper Valuing people: a new strategy for learning disability for the 21st century* states that people with learning disabilities should have independence, choice, rights and inclusion (Dougall and Fiske, 2008; *Strategy for learning disability for the 21st century*, 2001). This is not the same as assuming that everyone with a learning disability has the capacity to make decisions. Some people with learning disability will have capacity, whilst others will not (Dougall and Fiske, 2008).

2.2.5-Hearing impairment

Not all hearing-impaired patients will wear a hearing aid or be able to hear clearly even when wearing one. Patients who do not respond to a question can appear to be less competent simply because they may have failed to hear the question. Care must be taken to avoid speaking from behind the patient or while still wearing a facemask, which is covering your lips (Henwood, Wilson and Edward, 2006).

2.3-Guideline related factor

Precisely what risks should be discussed with a patient is poorly defined and often left to the judgement of the individual practitioner, although there is a now gradual shift from the *Bolam19 standard* of 'what a reasonable practitioner would advise' towards 'what a reasonable patient would expect to hear (Ernst et al., 2007). There is no absolute regulation about how much information should be disclosed as part of this process; guidance is provided on the basis of case law, which itself is evolving. Current UK case law asserts that you cannot be held negligent if you fail to mention a risk which a reasonably competent doctor in a similar position would not mention, or if your actions are supported by a responsible body of relevant professional opinion, but you must inform patients of serious complications of surgery even if they are rare (Niall., et al., 2011; Sidaway v Board of Governors of Bethlem Royal and the Maudsley Hospital, 1985;

Bolam v Friern Hospital Management Committee, 1957; Chester v Afshar, 2004). Absence of a clear guidance in this part could be a cause of litigation between patient and practitioner.

3-Discussion

In establishing informed consent, patients need to be provided with adequate information about the clinical procedure including its intent, nature, sequelae, probability of success and all possible alternatives. Any information supplied to the patient about their treatment should be simple and clear. It is the responsibility of the dentist to ensure that the information provided to the patient is easily understood. It is important to avoid confusing medical terms, abbreviations or acronyms when conveying information to patients, (Henwood, Wilson and Edward, 2006). The consequences of not obtaining such consent can leave the practitioner open to allegations of negligence and, much less often, battery. Aside from the medico-legal aspects of consent, it has been shown that patients who are well informed comply better with any proposed treatment or intervention (Ernst et al. 2007; Dobree, 1989).

The patient's agreement to the treatment is an integral part of the consent process and the dentist's competence to provide it is a heady mix of self-appraisal and insight, professionalism and ethics (Cruz, 2010).

The person providing the information must have sufficient knowledge to explain the procedure, including the risks and alternative treatment options (Ernst et al., 2007). Commonly, the explanation of alternative treatment options is not always provided (Ernst et al., 2007; Ibrahim, Ong and Taylor, 2004). Similarly, most of the clinicians do not mention the consequence of not treating the disease. Assessing the level of understanding of the patient regarding the proposed treatment is another subject requiring more attention.

Certainly, it is known that the act of signing a consent form does not guarantee patient understanding of a proposed procedure and alone does not therefore constitute valid consent (Ernst et al., 2007; Byrne, Napier and Cuschieri, 1998; Chatterton v Gerson, 1981). Consent must therefore be considered a process of which signing the form is only one part. There is evidence that understanding, and by inference validity, is improved with the use of appropriate and well written patient information literature (Ernst et al. 2007; Askew, Pearson and Cryer, 1990; Langdon, Hardin and Learmoth, 2002).

Legally, if patients believe that clinicians have abused their right to make informed choices about their care, they can pursue a remedy in the civil courts for having been deliberately touched without their consent (battery) or for having received insufficient information about risks (negligence). To avoid the accusation of battery, clinicians need to make clear what they are proposing to do and why "in broad terms". With respect to negligence, the amount of information about risks required is that deemed by the court to be "reasonable" in light of the choices that patients confront (Doyal, 2001; Chatterton v Gerson, 1981; Chantler and Doyal, 2000).

There is good evidence that many clinicians are themselves poor communicators (Doyal, 2001; Braddock et al., 1999). Patients have consistently protested about the failure to communicate effectively and this is believed to be one of the key causes of increasing patient litigation and even more time consuming formal complaints. Poor communication about risks can lead to patients making potentially dangerous decisions about their medical treatment (Doyal, 2001; Dudley, 2001). Equally, clinicians have themselves revealed how inadequate their communication is with patients, even in circumstances where it should be of a high standard—for example, obtaining informed consent for participation in research (Doyal, 2001; Hall, 2000).

Finally, even the best trained clinician will require more than good communication skills to improve the standard of patient comprehension of clinical information and thus the process of informed consent itself. Good communication requires time and resources. When consultation times are so short and there is a paucity of well designed and produced literature and other informational aids for patients, even the best communicators will be hard pressed to educate patients to their full potential (Doyal, 2001; Elwyn et al., 1999; Shepperd, Charnock and Gann, 1999).

There has been much debate of the meaning of the terms 'competence' and 'capacity' in the scientific literature and the law and how they can be reliably verified (Henwood, Wilsonand Edward, 2006; Welie and Welie, 2001). An understanding of these terms is therefore of great importance when determining whether consent for treatment is valid (Henwood, Wilson and Edward, 2006).

The ability to assess a patient's capacity to make competent decisions concerning their own care is an important skill. This assumes even greater importance for clinicians treating the elderly,

chronically ill and other vulnerable groups living either on their own in the community or in residential care (Henwood, Wilson and Edward, 2006; Gallacher, 1999).

4-Conclusion

There are some key parts of informed consent in which many clinicians lack knowledge and understanding. The education and capacity of Practitioners need to be improved to satisfy their ethical obligation and legal requirement so that valid consent is obtained from patients before treatment is performed. The process of gaining a patient's consent for treatment, apart from being a necessary legal requirement, is an opportunity for patients to have healthcare that is based on their informed choice. The assessment of a patient's competence is an important part of the consent process and practitioners need to keep in mind that patients can be misunderstood and wrongly considered incompetent. Another area requiring more attention is the regulations. There should be a clear guidance for practitioners to explain the most common side effects and risks of each treatment, in addition of leaving it to their judgment of any specific risk to the patient. This way it gives better guidance to the dentist as they will know things they must do and other aspects can be left at the dentist's discretion. Improving the skills for better communication with the patient, in order to obtain adequate informed consent, will surely lead to more health literacy, less fear and more compliance by patients. On the other hand, it provides physicians with more rewarding practice, since better communication means better doctor/patient relationship and less risks of legal problems.

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Appendix 1 Informed consent questionnaire

NAME GDC Number

Informed Consent Questionnaire

1. For a patient to be able to consent to a course of treatment, what must the clinician explain to them? [3 answers]

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2. For a clinician to judge whether a patient has the capacity to give informed consent, what must the patient be able to demonstrate after all explanations have been given? [2 answers]

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3. In the case of a conscious adult deemed incapable of giving consent for a course of treatment that cannot be delayed, explain how best to proceed. [4 answers]

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4. a) In the case of a patient aged between 16 and 18 who is deemed incapable of giving consent, can the patient's mother legally give consent?

YES/NO

b) Once the same patient reaches the age of 18, can his next of kin sign a consent form on his behalf?

YES/NO

5. If a competent child under 16 years of age consents to undergo a course of treatment, can the child's mother legally override that consent?

YES/NO

6. If a competent child under 16 years of age refuses to undergo a course of treatment, can the child's father legally consent instead? [3 answers]

YES/NO

Your answer needs to be qualified by TWO conditions which are:

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7. Is a signed consent form essential before non urgent treatment?

YES/NO

8. According to current Department of Health guidelines, can all major treatment complications with an incidence of less than 1% be omitted from being discussed during the process of obtaining consent?

YES/NO

9. According to current Department of Health guidelines, if a patient has signed a consent form more than 6 months prior to the treatment starting, must the patient re-sign the form for validity?

YES/NO

10. In those cases where some aspect of the patient's dental treatment cannot be performed without a general anaesthetic, who has responsibility for obtaining the anaesthetic consent? [2 answers]

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11. According to the GDC's May 2005 Standards Guidance, whenever a patient returns to start a course of treatment following an examination or assessment, must they be given a written treatment plan?

YES/NO