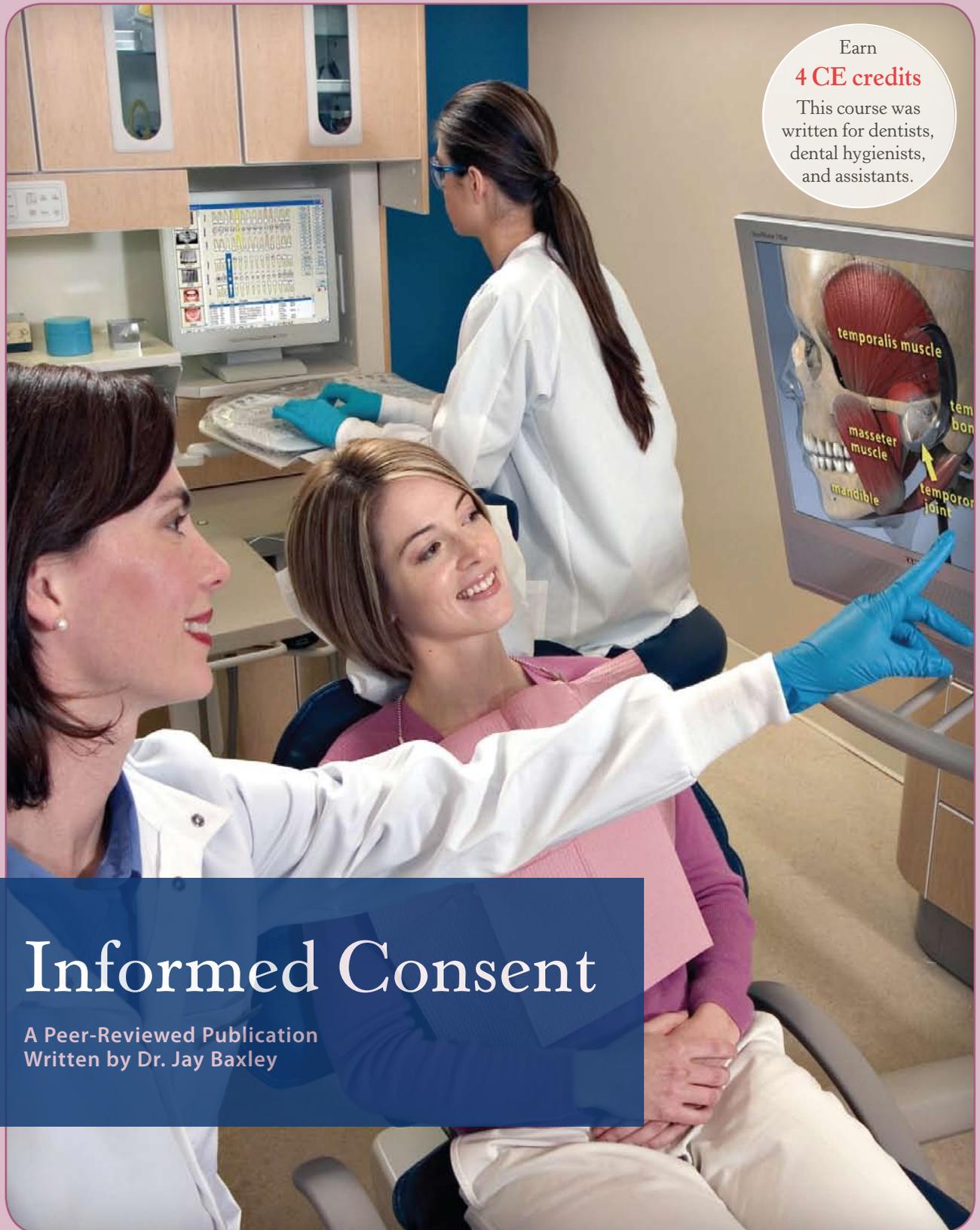


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# Informed Consent

A Peer-Reviewed Publication  
Written by Dr. Jay Baxley

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## Educational Objectives

Upon completion of this course, the clinician will be able to do the following:

1. Explain the difference between “consent” and “informed consent.”
2. Explain the importance of informed consent in today’s dental records.
3. Understand how to decide which scenarios require informed consent.
4. Explain which members of the dental team are qualified to obtain informed consent.
5. Explain the difference between “informed consent” and “informed refusal” and understand under what circumstances each should be used.
6. Understand under what conditions automated education systems can help in the informed consent process.

## Abstract

Treating a patient without “consent” constitutes a battery; treating a patient without “informed consent” constitutes negligence. Dentists must respond to a wake-up call that informed consent is no casual issue. If a procedure is “invasive or irreversible,” informed consent must be obtained; if the procedure is diagnostic in nature and the patient wishes to forgo the procedure, an “informed refusal” must be obtained. Although obtaining informed consent may at first seem awkward, cumbersome, and time consuming, it may very well save a practitioner countless hours in the courtroom and thousands of dollars in legal fees.

## Introduction

Long gone are the days when patients would enter a dental office, sit quietly in an operatory, and allow the dentist to perform whatever treatment he deemed necessary, and then pay the quoted fee in full on the way out...no questions asked. Today’s patients are better educated, more informed, and less trusting than patients were thirty years ago. They want to know exactly what their options are, how much it will cost, what will happen if they don’t receive the prescribed treatment, and how long they can delay expensive restorative treatment before serious repercussions occur. In addition, there is the added factor of dental insurance coverage, which is something no one had to consider prior to 1970. In today’s treatment arena, patients are often swayed by coverage benefits rather than prescribed treatment, leaving the dentist wide open to future litigation should the patient complain he or she was inadequately informed of options or repercussions, and if proper documentation of prescribed treatment cannot be found in the patient record.

Dentists, as a whole, are notorious for poor record keeping, but the idea of informed consent along with proper documentation has come full circle in the dental profession. Unlike their physician counterparts who have been acutely aware of informed consent for many years, dentists must respond to

a wake-up call that informed consent is no casual issue. Although procedures such as root canal therapy and extractions seem obvious when it comes to the need for informed consent, dental practitioners often overlook or take for granted minor procedures such as fillings and local anesthesia that also require informed consent. As we look at this critical issue, keep in mind that each state has varying nuances in its laws, but the idea of informed consent is universal.

## The History of Consent

The idea of consent, at least in the legal world, began as a simple defense to the tort of battery. Battery is defined as “the intentional and offensive touching of another without lawful justification.”<sup>1</sup> If there is “consent,” there is permission or lawful justification for the touching and therefore no claim to battery. Tort law generally accepts the view of *volenti non fit injuria*, meaning, “to one who is willing, no wrong is done.”<sup>2</sup> Consent, however, can occur in many forms. For example, the simple extension of the right hand to initiate a handshake is a nonverbal form of consent allowing the second party to grasp the hand of the first in a reasonably firm manner. It is not, on the other hand, consent for the second party to squeeze the hand of the first until his bones are crushed. In addition, an affirmative answer to the question, “May I borrow your car?” gives verbal consent to the normal use of a car but does not grant the borrower the privilege to jump curbs at will causing damage to the vehicle. Thus, common sense dictates that consent based on a misrepresentation or misunderstanding of the facts does not constitute true consent. (This idea will become more important when we discuss “informed” consent.)

Most courts hold that a defendant is privileged to make contact where the plaintiff’s words, gestures, or conduct reasonably manifest consent to it, even if the plaintiff was not actually willing to be touched.<sup>3</sup> To illustrate this idea of implied consent, one can look to *O’Brien v. Cunard SS Co.*, a famous case from 1891. Ms. O’Brien, the plaintiff, was aboard the defendants’ ship on her way to the United States. It was customary at that time for all immigrants that had not previously been vaccinated for smallpox to receive a smallpox vaccination on board prior to reaching the US shore. Although the plaintiff testified that she was unwilling to be vaccinated, she stood in line with over 200 other women, witnessing many of them receiving immunizations. When it was her turn to be vaccinated, she voluntarily held up her arm to receive the shot. It was later determined by the courts that the doctor was justified in giving her the vaccine, despite what her unexpressed feelings may have been.<sup>4</sup>

Some fourteen years later, however, there was evidence of a change and of things to come. In 1905, *Mohr v. Williams* gave us an example of how consent may allow one type of touching but not another. The physician in this case obtained consent from the patient to operate on her diseased right ear, but once in the operating room the physician found her left ear in worse condition. The surgeon proceeded to operate on

the left ear instead, and although the surgery was done well, the physician's treatment went beyond the scope of contact to which the patient had consented and was thus held to be battery by the courts.<sup>5</sup>

During the last quarter-century, advances in medical and dental treatments have given rise to a host of difficult consent issues now analyzed under the rubric of the "right to refuse treatment." Most courts now recognize the right of a competent adult to refuse treatment, even life-saving treatment (do not resuscitate orders), based on common-law battery principles and the constitutional right of privacy or liberty.<sup>6</sup> As caregivers, we often fail to understand why anyone would refuse treatment that would improve his or her overall health, but the courts have shown that society places a higher fundamental value on personal autonomy.

### The Importance of "Informed" Consent

By now, the idea of consent should be fairly clear. Consent must be obtained before any unwanted touching occurs, otherwise a battery has been committed. But what about "informed" consent? Exactly what is the difference between "consent" and "informed consent?" "Informed consent" is defined as, "a person's agreement to allow something to happen, made with full knowledge of the risks involved and the alternatives" or "a patient's knowing choice about a medical [dental] treatment or procedure, made after a physician [dentist] or other health care provider discloses whatever information a reasonably prudent provider in the medical community would give to a patient regarding the risks involved in the proposed treatment or procedure."<sup>7</sup> In short, informed consent is consent given by the patient based on additional information provided by the health care provider.

In the eyes of the law, dentists are experts in their chosen field and therefore bear a duty to their patients to share their knowledge, to the extent that a reasonable patient in the same circumstances would want to be educated, about his or her condition and the treatments or procedures available. That does not mean that a practitioner must engage in an explanation equal to the depth of three hours of dental continuing education. It does mean, however, that a dentist must inform, in layman's terms, the condition or disease present and the treatments available to the patient, whether or not the practitioner performs all of the treatments discussed. For example, a general dentist must discuss the option of implants as well as bridges, flippers, and partial dentures, even if that dentist does not place or restore implants, if he plans to remove a tooth or two on the lower right quadrant. The patient must understand not only the importance of replacing the extracted teeth but all of the available options to do so as well.

In addition, the practitioner must keep in mind that the patient's preconceived notions surrounding certain procedures in dentistry often block clear, rational decision-making capabilities unless the doctor offers conscientious, thorough information upon which the patient can base the consent. For instance, a patient seeks treatment for a toothache in which a carious exposure on a lower left first molar is present. The dentist's diagnosis/treatment plan calls for root canal therapy followed by full coronal restoration with a crown. The patient, having heard rumors for years that root canals are painful and simply do not work, immediately informs the doctor that she does not wish to have root canal therapy. The doctor, not wanting to go against the wishes of the patient, gladly agrees to extract the tooth, and in fact does so after obtaining a signed, written consent for the extraction. The dentist in this scenario, however, failed to inform the patient that the molar in question was the last periodontally stable tooth in the quadrant, leaving the existing lower removable partial denture with no anchoring abutment on the left side after the extraction. After returning home, the patient places the lower partial back into position and realizes that it is no longer stable when she speaks and chews. Not happy with the first dentist, the patient seeks the advice of a second dentist who tells her she is destined for a lower denture or implants or some combination of both. The patient's response is simply, "Had I known that I was going to lose my partial, I would have most likely gone ahead and done the root canal to save the tooth."

As the above example shows, most treatments involve consequences far beyond the understanding of most patients. After all, the patient is not the expert and must rely upon the dentist for information as to what may happen to him or her in the future. Although the patient signed an informed consent regarding the risks and dangers involving the extraction itself, no "informed" consent was given for the "treatment" since the first dentist failed to give the patient adequate information to make a rational decision overall. As is often the case in the dental office, patients arrive in pain and simply want the pain to stop no matter what the consequences. In such cases, it is best to alleviate the pain with local anesthetic to allow a less clouded judgment and normal thought process to emerge. In the eyes of the law, a person cannot consent to anything if his or her judgment is impaired in any way. This was often meant to include drugs and alcohol, which remove the ability to make sound decisions, yet pain should also be included in this category since it too often impairs the ability to think in a rational manner.

Informed consent protects not only the patient but the doctor as well. It is simply a signed document acknowledging that the patient understands all of the ramifications surrounding a certain condition and treatment options available. In some cases, informed consent may be in the

form of an “informed refusal.” For example, a patient who has been diagnosed with advanced periodontal disease may elect to have no treatment at all and allow nature to take its course resulting in the slow loss of his or her remaining dentition. Patients have the ultimate say when it comes to treatment, but it is the practitioner’s duty to make sure all options for treatment are explored. In this case, a signed refusal protects the doctor by documenting the conditions found and the treatment options presented.

## What Dental Treatments Require An Informed Consent?

As the need for informed consent becomes more evident to the dental profession, the common question arises as to which procedures actually require written, informed consent. The answer to that question is relatively straightforward: Any procedure that is “invasive or irreversible” requires informed consent. The fact that a patient goes to an office for an exam implies that he or she wants the doctor to perform some type of clinical exam to determine what might be needed, but most dentists take for granted the fact that more than 90 percent of their procedures are surgical in nature. All procedures, from a simple buccal pit restoration to the removal of a complicated, full boney, impacted third molar, require an irreversible change to bodily tissues with the risk of some type of complication or unwanted side effect. Even minor occlusal/incisal adjustments can affect the surrounding dentition, cuspid rise, masticatory function, or TMJ stability. The mouth is an extremely dynamic environment, subject to the forces of the tongue, lips, cheeks, and teeth. Any change to that environment, even with the best of intentions by the practitioner, may lead to unwanted results, and those possibilities need to be presented to the patient and documented in writing.

Although “invasive and irreversible” procedures require informed consent, most diagnostic procedures such as clinical exams, periodontal probings, and radiographs do not require such formal consent. It is assumed, for the most part, that patients want the doctor to obtain all of the information necessary to make a complete and accurate assessment of the oral condition when scheduling for an initial exam, cleaning, or toothache exam. On occasion, however, patients will specifically state that they wish to forgo diagnostic procedures such as radiographs or periodontal probings. The practitioner’s focus must immediately turn to “informed refusal” in these cases. To substantiate this, one must look no further than *Truman v. Thomas* in which a physician was found liable for failing to warn a patient of the risk of refusing a Pap smear test.<sup>8</sup> Patients must be informed, in writing, that refusing radiographs may lead to undetected decay, abscesses, or bone loss, and that refusing periodontal probings will prevent an accurate assessment of periodontal health which may

lead to eventual shifting of the dentition or complete tooth loss. Patients, especially those that are pain-free, often fail to understand the need for certain diagnostic procedures, but once informed of their importance either submit to the procedure or gladly sign an “informed refusal.” In either instance, it is a win-win situation for both patient and practitioner; if the patient submits to the diagnostic procedure, then an accurate diagnosis can be made, but if the patient refuses the diagnostic procedure, there is written documentation proving that the need was discussed between doctor and patient.

In summary, the following general rule should be followed: If the procedure is “invasive or irreversible,” informed consent must be obtained, but if the procedure is diagnostic in nature and the patient wishes to forgo the procedure, an “informed refusal” must be obtained.

## What Information Is Needed For Informed Consent?

It is NOT sufficient that a dentist simply document in the chart that he or she “went over all risks of treatment and the patient understands.” Specific risks must be written down, and patients must be given the opportunity to discuss with the doctor and question those issues which they do not understand. It is highly recommended that the practitioner have a written informed consent form for each procedure that is performed in his or her office.

Although there is no mandatory set format for how an “informed consent” should be written, there are several key points that should be included. First, a description of the procedure to be performed should be listed. This does not have to be long, but it should be accurate and specific. For example, a listing of “lower right composite” would be too general. Instead, it would be best to label it as “MO composite tooth #30,” so that not only the specific tooth but also the surfaces involved are listed. Second, a list of the inherent risks involved in the procedure should be listed. This list does not have to be exhaustive but should cover those risks that are realistic to the procedure. For example, death is an extremely rare risk resulting from a composite. (Hopefully, the risk of death was covered on the “anesthesia consent” obtained prior to the “composite consent.”) However, the risks of a mechanical pulpal exposure, lacerated tongue or cheek, or postoperative sensitivity are realistic and should be included on the consent form. Obviously, the more risks that are listed, the more protected the practitioner will be should a problem arise. Be sure that if the list uses scientific terminology that there is a layman’s explanation beside it. After all, patients must understand what they are consenting to,

Figure 1: Sample Local Anesthesia Consent Form

LARRY DOE, DDS  
3350 MAIN ROAD  
ANYWHERE, USA  
(800) 555-5555

LOCAL ANESTHESIA CONSENT FORM

THIS CONSENT FORM IS DESIGNED TO MAKE YOU AWARE OF THE RISKS INVOLVED WITH LOCAL ANESTHESIA. THE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

- THERE ARE RISKS OF ANESTHESIA THAT MAY AFFECT YOUR BODY, SUCH AS DIZZINESS, NAUSEA, VOMITING, ACCELERATED HEART RATE, SLOW HEART RATE, OR VARIOUS TYPES OF ALLERGIC REACTIONS ANY OR ALL OF THESE MAY REQUIRE ADDITIONAL MEDICAL MANAGEMENT OR HOSPITALIZATION.
- RESTRICTED MOUTH OPENING DURING RECOVERY, SOMETIMES RELATED TO MUSCLE SORENESS AT THE SITE OF THE INJECTION REQUIRING PHYSICAL THERAPY.
- LOCAL ANESTHESIA MAY CAUSE PROLONGED NUMBNESS, THAT IN SOME PATIENTS MAY RESULT IN INJURY FROM BITING OR CHEWING AN AREA SUCH AS (LIP, CHEEK OR TONGUE) THAT HAS RECEIVED THE LOCAL ANESTHESIA.
- INJURY TO NERVES THAT CAN RESULT IN PAIN, NUMBNESS, TINGLING, OR OTHER SENSORY DISTURBANCES TO THE CHIN, LIP, CHEEK, GUMS, OR TONGUE. THIS MAY PERSIST FOR SEVERAL WEEKS, MONTHS OR RARELY, BE PERMANENT.
- LOCAL ANESTHESIA IS ADMINISTERED WITH A VERY SMALL FINE NEEDLE. IN VERY RARE INSTANCES THESE NEEDLES MAY BREAK OFF AND BE LODGED IN SOFT TISSUE.

PLEASE ASK THE DENTIST IF YOU HAVE ANY QUESTIONS REGARDING THIS CONSENT FORM. DO NOT INITIAL OR SIGN ANY BLANK IF YOU HAVE NOT HAD YOUR QUESTIONS ANSWERED.

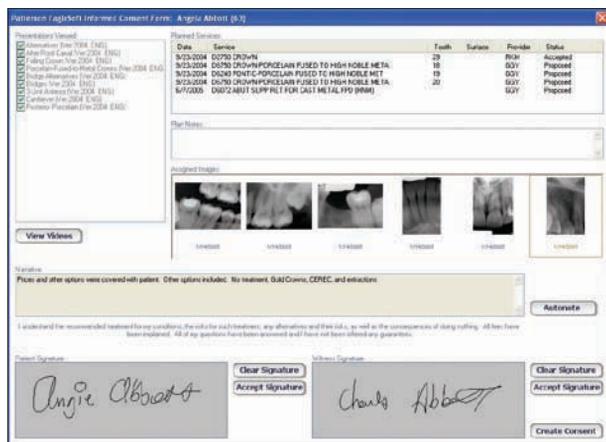
I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT, AND HAVE DISCUSSED ALL QUESTIONS OR CONCERNS THAT I MIGHT HAVE REGARDING LOCAL ANESTHESIA.

PATIENT OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

DOCTOR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Figure 2: Sample Digital Chart



otherwise the consent is invalid. Third, there should be wording to the effect that the patient attests that he or she understands the inherent risks involved in the procedure and has had the opportunity to discuss such risks with the health care provider. This should be immediately followed by the patient's signature/date, doctor's signature/date, and witness's signature/date. Make sure that the patient's name is legibly printed somewhere on the form since some signatures are illegible. In most cases, a consent form need be little more than one page for most dental procedures if it is organized well. (See the example of a local anesthesia consent form in Figure 1.)

For those practitioners who do not feel comfortable putting together their own informed consent forms, it is best to either consult an attorney or contact a malpractice carrier. The latter approach will most likely be easier and more cost effective since obtaining informed consent on a well-written form benefits both the practitioner and the

malpractice carrier. Most carriers will be happy to help you with this endeavor, but if they don't, consider going with a carrier that offers such a service.

## Gathering An Informed Consent

Once a practitioner has gathered a supply of informed consent forms for the various procedures that he or she does in his or her office, obtaining consent from the patient is relatively easy. After defining exactly what procedure is to be done that day, the practitioner may take the traditional approach of a face-to-face explanation of the procedure and its inherent risks and then answer questions as they arise. However, in today's high-tech world it is perhaps easier and more time-efficient to allow universally accepted patient education systems to do the work for you. For offices that have such systems in place, it is simply a matter of allowing the patient to watch pre-recorded video clips detailing the procedure and risks that are about to occur. Afterward, the doctor need only address those questions that the patient may still have concerning the upcoming treatment. The doctor should note on the consent form that the patient watched the appropriate presentation and then obtain the necessary signatures to complete the consent process. Make sure that the education system covers each risk that is listed on your written consent form; if not, you must go over the additional risks face-to-face. Some dental software programs allow the doctor to create the Patient Informed Consent Agreement record directly from the Treatment Plan screen, adding radiographs, images, notes, and viewed presentations directly to the record. In that case, the patient can then digitally sign the agreement and it can be stored with the patient's digital chart. (Figure 2.)

In addition, for those offices that do not use automated education systems, it is extremely important that the practitioner conduct each informed consent personally and not delegate such tasks to auxiliary personnel. In the eyes of the law, the dentist is the expert and he or she is the only one capable of obtaining a proper informed consent from the patient. If auxiliary personnel obtain informed consent, patients may later claim that their questions were answered inaccurately, regardless of what was actually said by either party at the time the consent was obtained. In a court of law, the defense will now be forced to prove that the auxiliary personnel that obtained the consent were in fact qualified to discuss all of the options with the patient. Without a dental degree, this level of proof will be impossible.

## Conclusion

Although the idea of informed consent is not new to hospitals and physicians, its uptake and widespread, systematic use within the dental community has been slow to evolve. After all, physicians perform procedures that can scar, maim, or even leave a patient paralyzed. Reper-

cussions such as these rarely occur in the dental setting. However, in dentistry, just as in medicine, unforeseen mishaps occur despite our best efforts. Therefore, it is just as important for dentists to obtain informed consent prior to every invasive and/or irreversible procedure. At first glance, most patients appear friendly and most dental procedures appear routine, but once a procedure goes wrong, an unhappy patient with a skillful attorney can become a dentist's worst nightmare. A signed, written informed consent may be the only evidence that the mishap that occurred was a foreseeable risk acknowledged by the dentist and accepted by the patient.

In short, a rule-of-thumb in dentistry is if the procedure is invasive or irreversible, it requires "informed consent." If the procedure is diagnostic in nature (i.e. radiographs or probings), and the patient refuses the test, then an "informed refusal" must be obtained from the patient. Treating a patient without "consent" constitutes a battery, but treating a patient without "informed consent" constitutes negligence. Although obtaining informed consent may at first seem awkward, cumbersome, and time-consuming, it may very well save a practitioner countless hours in the courtroom and thousands of dollars in legal fees should some mishap occur.

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3. Restatement (Second) of Torts §892 (2).
4. O'Brien v. Cunard SS Co., 28 N.E. 266 (Mass. 1891).
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6. Joseph W. Glannon, The Law of Torts: Examples & Explanations, p. 46 (2nd ed. 2000).
7. Black's Law Dictionary, p. 130 (2nd pocket ed. 2001).
8. Truman v. Thomas, 611 P.2d 902 (Cal. 1980).

## Author Profile

### Dr. Jay Baxley



Dr. Baxley obtained his undergraduate degree from Baylor University in 1982 and his DDS degree from Baylor College of Dentistry in Dallas in 1986. He has since owned and managed large, multi-chaired offices in Austin, TX, and the Dallas/Ft. Worth area. He currently operates a high-tech, eight-chair, solo office in Arlington, TX. Dr. Baxley is currently the Texas Dental Association Chairman for the Council on Ethics and Judicial Affairs and has studied law at Texas Wesleyan University School of Law in Ft. Worth.

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## Questions

- Today's patients are \_\_\_\_\_ than patients thirty years ago.
  - better educated
  - less trusting
  - more informed
  - all of the above
- Patients are often swayed by \_\_\_\_\_ rather than prescribed treatment.
  - coverage benefits
  - false expectations
  - family members
  - none of the above
- The idea of consent began as a simple defense to \_\_\_\_\_.
  - the tort of assault
  - the tort of battery
  - the tort of negligence
  - none of the above
- Which of the following can nullify true consent?
  - misnomer
  - mistake
  - misrepresentation
  - none of the above
- To obtain informed consent a dentist must \_\_\_\_\_.
  - inform the patient of the condition or disease present.
  - inform the patient of all treatments available.
  - explain everything in layman's terms.
  - all of the above
- The idea that consent must be defined by specific boundaries was brought to light by \_\_\_\_\_.
  - O'Brien v. Kennard SS Co.
  - Roe v. Wade
  - Mohr v. Williams
  - none of the above
- The idea that competent adults have the right to refuse treatment is based upon \_\_\_\_\_.
  - common sense
  - common-law battery principles
  - the constitutional right of privacy
  - b and c
- Society places a \_\_\_\_\_ value on personal autonomy.
  - low
  - high
  - average
  - ridiculous
- The idea of implied consent was made famous by what case?
  - Roe v. Wade
  - Mohr v. Williams
  - O'Brien v. Kennard S.S. Co.
  - none of the above
- Informed consent is consent given by the patient based on additional information provided by the \_\_\_\_\_.
  - assistant
  - dentist
  - office manager
  - any of the above
- A patient's preconceived notions surrounding certain procedures in dentistry have nothing to do with his or her clear, rational decision-making capabilities.
  - True
  - False
- The idea of "informed refusal" was brought forth by \_\_\_\_\_.
  - Roe v. Wade
  - Truman v. Thomas
  - Mohr v. Williams
  - none of the above
- Informed consent should be obtained when \_\_\_\_\_.
  - a procedure is expensive
  - the patient appears nervous
  - the procedure is irreversible
  - the patient refuses a diagnostic procedure
- Informed consent should be obtained for the following procedures:
  - local anesthesia
  - composite fillings
  - occlusal equilibration
  - all of the above
- It is sufficient that a dentist simply document in the chart that he or she "went over all risks of treatment and the patient understands."
  - True
  - False
- A written "informed consent" should contain \_\_\_\_\_.
  - a description of the procedure to be performed
  - a list of the inherent risks involved in the procedure
  - a place for patient's, doctor's, and witness's signature
  - all of the above
- A written informed consent protects \_\_\_\_\_.
  - the doctor
  - the patient
  - the malpractice carrier
  - all of the above
- In the eyes of the law, a person cannot consent to anything if his or her judgment is impaired in any way.
  - True
  - False
- Over \_\_\_\_\_ of the procedures in dentistry are surgical.
  - 50%
  - 60%
  - 75%
  - 90%
- When obtaining an informed consent, it is best to use as much scientific terminology as possible to keep the patient in the dark.
  - True
  - False
- All written informed consent forms should list the following risks:
  - only those that the dentist has had prior experience with
  - those that are realistic to the procedure being covered
  - death
  - only those that the patient is concerned about
- Before obtaining an informed consent, the risks must be explained by \_\_\_\_\_.
  - a face-to-face conversation between dentist and patient
  - an automated education system such as CAESY
  - an auxiliary with more than ten years' experience
  - a and b only
- Which of the following scenarios would require an "informed refusal?"
  - a patient that doesn't want x-rays
  - a patient that doesn't want periodontal probings
  - none of the above
  - Both A and B
- Treating a patient without consent constitutes \_\_\_\_\_.
  - an assault
  - a battery
  - negligence
  - none of the above
- Treating a patient without "informed consent" constitutes \_\_\_\_\_.
  - an assault
  - a battery
  - negligence
  - none of the above
- Failing to obtain informed consent for an invasive or irreversible procedure may \_\_\_\_\_.
  - cause the doctor to spend thousands of dollars in legal fees later
  - cause the doctor to spend countless hours in depositions and courtrooms
  - cause the doctor some added stress if the patient files a claim of malpractice
  - all of the above
- After a patient views a pre-recorded educational clip covering the risks involved in a certain procedure, the doctor should:
  - discuss face-to-face those risks not covered by the clip
  - ask the patient if he or she has any questions regarding the information viewed on the clip
  - just get the signature and move on
  - a and b
- If a patient is in extreme pain, the doctor should \_\_\_\_\_.
  - get the consent signed while tears are still in the patient's eyes
  - administer local anesthesia to allow the patient to make a clear, rational decision
  - tell the patient he or she is going to have to make a decision before the doctor can do anything
  - refuse to see the patient until he or she stops crying
- When a dentist explains a procedure and its associated risks to a patient he or she must \_\_\_\_\_.
  - make his or her explanation equal to that of what a reasonable patient would want to know
  - hit the high points and move on
  - make his or her explanation as detailed as possible so that the patient also becomes an expert
  - give the patient a written test to prove he or she understands
- On a written consent form, the description of the procedure to be performed should be \_\_\_\_\_.
  - general
  - specific, so that boundaries are clear
  - vague, so as to cover all bases
  - none of the above

# Informed Consent

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ E-mail: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: Home (     ) \_\_\_\_\_ Office (     ) \_\_\_\_\_

Requirements for successful completion of the course and to obtain dental continuing education credits: 1) Read the entire course. 2) Complete all information above. 3) Complete answer sheets in either pen or pencil. 4) Mark only one answer for each question. 5) A score of 70% on this test will earn you 4 CE credits. 6) Complete the Course Evaluation below. 7) Make check payable to PennWell Corp.

## Educational Objectives

1. Explain the difference between "consent" and "informed consent."
2. Explain the importance of informed consent in today's dental records.
3. Understand how to decide which scenarios require informed consent.
4. Explain which members of the dental team are qualified to obtain informed consent.
5. Explain the difference between "informed consent" and "informed refusal" and understand under what circumstances each should be used.
6. Understand under what conditions automated education systems can help in the informed consent process.

## Course Evaluation

Please evaluate this course by responding to the following statements, using a scale of Excellent = 5 to Poor = 0.

1. Were the individual course objectives met?	Objective #1: Yes No	Objective #4: Yes No
	Objective #2: Yes No	Objective #5: Yes No
	Objective #3: Yes No	Objective #6: Yes No

2. To what extent were the course objectives accomplished overall?	5	4	3	2	1	0
3. Please rate your personal mastery of the course objectives.	5	4	3	2	1	0
4. How would you rate the objectives and educational methods?	5	4	3	2	1	0
5. How do you rate the author's grasp of the topic?	5	4	3	2	1	0
6. Please rate the instructor's effectiveness.	5	4	3	2	1	0
7. Was the overall administration of the course effective?	5	4	3	2	1	0
8. Do you feel that the references were adequate?		Yes	No			
9. Would you participate in a similar program on a different topic?		Yes	No			
10. If any of the continuing education questions were unclear or ambiguous, please list them.	_____					
11. Was there any subject matter you found confusing? Please describe.	_____					
12. What additional continuing dental education topics would you like to see?	_____					

Mail completed answer sheet to  
**Academy of Dental Therapeutics and Stomatology,**  
 A Division of PennWell Corp.  
 P.O. Box 116, Chesterland, OH 44026  
 or fax to: (440) 845-3447

**For IMMEDIATE results, go to [www.ineedce.com](http://www.ineedce.com) and click on the button "Take Tests Online." Answer sheets can be faxed with credit card payment to (440) 845-3447, (216) 398-7922, or (216) 255-6619.**

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1. (A) (B) (C) (D)	16. (A) (B) (C) (D)
2. (A) (B) (C) (D)	17. (A) (B) (C) (D)
3. (A) (B) (C) (D)	18. (A) (B) (C) (D)
4. (A) (B) (C) (D)	19. (A) (B) (C) (D)
5. (A) (B) (C) (D)	20. (A) (B) (C) (D)
6. (A) (B) (C) (D)	21. (A) (B) (C) (D)
7. (A) (B) (C) (D)	22. (A) (B) (C) (D)
8. (A) (B) (C) (D)	23. (A) (B) (C) (D)
9. (A) (B) (C) (D)	24. (A) (B) (C) (D)
10. (A) (B) (C) (D)	25. (A) (B) (C) (D)
11. (A) (B) (C) (D)	26. (A) (B) (C) (D)
12. (A) (B) (C) (D)	27. (A) (B) (C) (D)
13. (A) (B) (C) (D)	28. (A) (B) (C) (D)
14. (A) (B) (C) (D)	29. (A) (B) (C) (D)
15. (A) (B) (C) (D)	30. (A) (B) (C) (D)

AGD Code 555

**PLEASE PHOTOCOPY ANSWER SHEET FOR ADDITIONAL PARTICIPANTS.**

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