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The American Academy of Pediatric Dentistry
Volume 6 Number 4

The legal status of informed consent for behavior management techniques in pediatric dentistry

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Abstract

The use of various nonpharmacologic behavior management techniques is an integral part of pediatric dental practice. These techniques enjoy broad-based acceptance within the profession, but until recently there has been little systematic attempt to ascertain the opinion of parents on the issue of behavior management. New findings suggest that many parents do not approve of the more commonly used management techniques. This article evaluates the significance of these findings in light of the current trend in informed consent law toward adoption of the "reasonable patient" standard of disclosure. When informed consent is analyzed in this manner, the dentist must disclose all aspects of proposed dental care which an average parent would find material or objectionable. The authors conclude that express parental consent must be obtained prior to the use of several behavior management techniques including HOME, restraining devices, and physical restraint by dental personnel, if the dentist is to avoid legal liability.

A common problem encountered in the practice of pediatric dentistry is management of the uncooperative child. Several nonpharmacologic behavior management techniques are used widely among pediatric dentists when treating these patients. These include positive reinforcement, tell-show-do, voice control, hand-over-mouth-exercise (HOME), and physical restraint.[1] while dentists employ these techniques based on continued success and professional approval,[2] little attention has been given to parental attitudes regarding their use. In light of recent findings,[3,4] health professionals can no longer assume parental approval for some of the most routine behavior management techniques, no matter how appropriate their use may appear.

This article will examine the legal status of informed consent with regard to the use of certain behavior management techniques. The topic is an important one for the profession primarily because many dentists neglect the issue of prior consent for behavior management. This oversight now may result in legal liability based upon two recent significant developments. First, there has been a nationwide trend in the law toward expansion of patient's rights with the attendant effect of expanded legal requirements for informed consent.[5-7] Second, recent findings indicate that certain behavior management techniques meet with general disapproval from parents.[3] It will be argued that, taken together, these two factors dictate that express parental consent must be obtained prior to the use of these behavior management techniques.

Legal Background Review

The Doctrine of Informed Consent

American law always has required that a health care professional obtain a patient's or parent's general consent before proceeding with treatment. Treatment without consent long has been recognized as a technical battery.[7,8] Until fairly recently, however, there was no legal recognition that a patient's consent also had to be "informed" in order to be valid.[5] This newer requirement is traced most frequently to the 1957 California case of *Salgo v. Leland Stanford, Jr., University Board of Trustees*.[9] This case, and its progeny, have added to the law of consent a requirement that there be disclosure of sufficient information to allow a patient to make an informed personal choice regarding the decision of whether to proceed with recommended treatment.[7]

In the years since the *Salgo* ruling most courts have agreed that consent is valid only if it is informed. Patients are entitled not only to know the general nature of proposed treatment, but also to decide if this intervention is acceptable to them after considering the risks, benefits, and treatment alternatives.

In fact, the patient has the right to choose to forego treatment altogether if any aspect is sufficiently objectionable to him, even if that decision would seem unreasonable to the health care professional.[7] This new focus in the law of consent is reflective of more general societal trends in the area of patients' rights[5] and in proplaintiff liberalization of tort law as a whole.[10,11] The swell of support for patients' rights is reflected clearly in the rapid growth of informed consent cases which have appeared in recent years, especially the past decade.[5,7]

Express vs Implied Consent

Informed consent encompasses both express and implied consent. Express consent is that which a patient gives directly for a specific procedure. Implied consent is that which arises by reasonable inference from the patient's actions even though there was no explicit consent given.[5]

If a dentist obtained *express* parental consent for the use of a specific behavior management technique such as HOME, no dispute regarding consent would arise. Instead, problems in this area tend to occur due to confusion about whether the parent has granted *implied* consent to the use of behavior management techniques based upon their *express* consent to general dental treatment for their child.[5, 12]

Judges long have recognized that the real-world health care professional cannot disclose every conceivable detail of treatment with a patient (or with the parent of a minor patient). When a patient seeks and approves proposed dental treatment, the law recognizes an implied consent to all normal and expected components or details of the treatment involved.[5] Consequently, the question is: Are behavior management techniques a normal and expected component of dental treatment, or are they sufficiently unusual or objectionable that the dentist must obtain separate consent for their use? The answer basically depends upon whose perspective is used to define what constitutes normal and expected components of treatment.

Professional Community vs Reasonable Patient Standard

As soon as courts began ro rule that a patient's consent to treatment was valid only if it were an informed consent, it became necessary to devise a set of guidelines setting forth what specific information the health professional was required to provide.[5, 7] The initial trend in the court rulings was to measure the sufficiency of information disclosed by reference to professional custom or the standard of practice within the profession. Until recently, the overwhelming majority of American states followed this "professional community" standard. Under this standard, a patient's consent was deemed to be informed legally if the doctor had made those disclosures which a reasonable practitioner would make under the same or similar circumstances.[5, 13] This was consistent with judicial analysis in other areas of medical malpractice, and it reflected a more general trend of deference to professional expertise in matters involving medical or dental practice.[14]

Under the professional community standard, a doctor could be held liable for nondisclosure only if the standard of professional practice were violated by failing to disclose the information at issue. Recent surveys[2] indicate the widespread use and acceptance of HOME in pediatric dentistry in selected cases. Reports also indicate a professional community belief that obtaining prior consent for HOME may be both impractical and inadvisable, especially if obtaining consent would necessitate interruption of the dental procedure.[15, 16] Evidence of this nature effectively would dispose of the consent issue for common behavior management techniques in states which follow the professional community standard of informed consent. Nondisclosure would be viewed as professionally reasonable, and parental consent would be implied as a part of the general consent to treatment. The practioner would face legal liability for behavior management only if the techniques were executed improperly by professional standards.

Over the course of the past decade, an alternative to the professional community standard of disclosure has developed in American courts. This more modern rule on informed consent focuses on the informational needs of the average, reasonable patient rather than on professionally established standards of disclosure. Under this new "reasonable patient" or "materiality" standard, a practioner may be held liable if the patient (or parent) did not receive all information that was material or consequential to their decision to accept or reject proposed treatment.[5, 17]

The new reasonable patient rule removes the decision of what information to disclose from the profession and gives it to the lay jury.[5, 7] Courts adopting the new rule require prior disclosure of all aspects of the treatment which the practitioner should know would be considered significant by the average patient.[18] Cases decided to date suggest that there will be an implied consent only to those aspects of treatment that the average patient would anticipate and approve. For example, consent would be implied for touching the face and use of a mouth mirror and explorer if general consent was given for a dental examination. These are procedures that a lay jury would agree are common and expected aspects of an examination.[19] Aspects of treatment that the average patient would not consider to be common and expected would have to be disclosed expressly regard-

less of their acceptance and approval within the professional community.

As illustrated in Figure 1, the reasonable patient or materiality standard thus far has enjoyed great success in displacing the traditional professional community standard among courts that have addressed the issue. In the 11 years following the landmark 1972 ruling in *Canterbury v. Spence*,[20] in which the new rule was adopted in the District of Columbia, 16 jurisdictions or states have adopted the new patient-based standard of disclosure expressly. The law on this issue is unclear in another 11 states, leaving 24 states which adhere to the professional community standard.[a]

Given the present proplaintiff trend on this issue, and in the law of torts more generally,[11] patient perceptions of what consitutes appropriate practice will become critically important to the practitioner. Therefore, new findings on parental attitudes toward behavior management deserve close evaluation by those who employ these techniques.

Parental Attitudes Toward Behavior Management

As informed consent law begins to encompass a new standard reflecting an emphasis on patient autonomy, the health care professional must become sensitive to societal acceptability of treatment modalities.[7, 21] The study conducted by Murphy et al.[3] involved assessment of parental attitudes toward currently used behavior management practices in pediatric dentistry. Both pharmacologic and nonpharmacologic approaches were assessed. Techniques employing drugs, such as sedation and general anesthesia, were rated by the sample of parents as among the least acceptable methods of behavior management. Since dentists are aware of the medical risks involved in using pharmacologic techniques, it is standard professional practice to obtain express parental consent for them. Thus, the new rule standard will not affect greatly this area of behavior management.

The same investigation also revealed that the use of HOME and restraint devices were viewed as unacceptable by a majority of the parents sampled. Although the use of these nonphamacologic techniques is viewed by the profession as psychologically neutral to the child,[22] the parents in the study felt that the use of HOME and restraint devices had severity comparable to sedation and general anesthesia.[3, 4] To these parents, it would be as important for them to be made aware of the potential use of HOME or restraint as it would be for the use of pharmacologic techniques. Of course, the results may not be generally applicable or indicative of the attitudes of all parents. On the other hand, the results of this study cannot be ignored since they represent the only exisiting objective indication of parental attitudes toward various behavior management techniques.

Any procedure which can be demonstrated to be objectionable to the average parent requires express consent under the new patient-based standard of informed consent. In states following the new rule, the dentist who uses HOME or patient restraint techniques should obtain express parental consent for their use if legal entanglements are to be avoided. The findings of Murphy et al.[3] make it clear that nondisclosure of these procedures would by definition violate the requirement that the dentist disclose all aspects of treatment that are material or significant to the average parent.

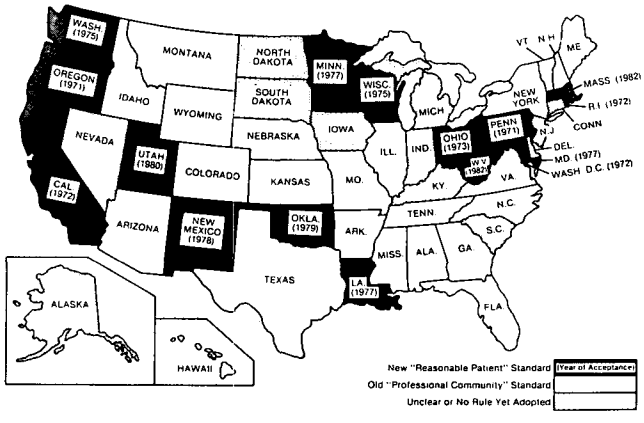

Figure 1. Standards of disclosure for informed consent in the United States as of December, 1983.

[a]Citations to state case rulings and statutory provisions may be obtained from the authors upon request.

Discussion

While the trend toward increased requirements for parental consent is very clear in general terms, a few related points warrant discussion. The law of informed consent currently is undergoing fairly rapid change. A distinct national trend over the past decade has been to move away from the traditional professional community standard of disclosure and to adopt in its place a standard reflecting the patient's perspective. This trend is not one-dimensional and some states will continue to abide by the old professional community standard. In fact, several states have either solidified or readopted the traditional rule by way of legislative action. This present state of flux in the law means that requirements will vary tremendously from state to state, and that any given state's law always should be considered susceptible to revision. The prudent practitioner is well advised to pursue a course of practice which will satisfy the most

rigorous informed consent scenario. The dentist will minimize legal problems by obtaining express consent for any procedure which the average patient might find objectionable.

Some authors have suggested that the use of behavior management techniques may not require express consent even in those states following the new patient-based rule of informed consent.[15] This position is based on several possible arguments. One is that the dentist stands *in loco parentis*, or in the position of the parent with regard to the child patient. Another is that the dentist enjoys a "therapeutic privilege" to withhold information which might be dangerous to the patient's physical or psychological well-being. Neither of these principles will serve as an effective legal defense for the application of behavior management techniques without prior parental consent. Some professionals, most notably school teachers, have an implied right to discipline and control unruly children as an integral part of their official functions. This implied authority exists because the professional stands *in loco parentis* in the eyes of the law. However, judgment appears to be unanimous that consent to dental treatment for a child does not confer such legal status upon the dentist.[15, 19, 23]

Similarly, the doctrine of therapeutic privilege has no application in a case involving nondisclosure of the use of behavior management techniques. The doctrine originally was intended only for cases of severe or life-threatening situations, where full disclosure might preclude patient rationality or cause psychological trauma. It has never been construed to justify nondisclosure of all unsettling aspects of treatment.[14, 18] In fact, it has been suggested that the privilege may not exist where disclosure is being made to a representative, such as a parent, instead of to the patient directly.[12] While there has been no authoritative court ruling on this point, the practitioner who asserts a privilege to withhold material information from a parent concerning their child's treatment is on questionable legal ground.[24]

When they are used properly, most common behavior management techniques typically would not cause noticeable physical injury to a patient. Obviously, a lawsuit charging the unconsented use of HOME, for example, would not involve a serious claim for the large dollar amounts that are common in cases involving much more catastrophic and demonstrable patient injuries. In fact, the practitioner may develop a sense of false security by the belief that there can be no liability where there is no physical injury. This clearly is not the case. Failure to obtain express consent for any material medical fact constitutes a legal wrong to the patient, even if no physical injury occurs.[25-27] Recent commentary has suggested that proof of the legal wrong automatically will trigger liability and an award of at least nominal damages. Beyond this, the successful plaintiff in an informed consent case may be entitled to further compensation for pain and suffering and mental distress.[10, 14, 28] It even is conceivable that, given the evidence of parental attitudes in the professional literature, a plaintiff could make a case of willful nondisclosure. In that instance, the case would rise from the level of malpractice to battery and potentially could justify an award of punitive damages set in an amount designed to punish the dentist. There is an unmistakable tendency in American law to impose increased liability on any person who intentionally invades the rights of another, even if no malice or wrong were intended.[8]

As a final point, it must be stressed that the new standard of liability for violation of the informed consent doctrine is designed only to give patients and parents a more meaningful guarantee of personal choice in health care matters. The goal is not to force practitioners into court just to get them to change their disclosure practices.[14] The move to a patient-based disclosure standard very well may result in a short-term increase in the volume of informed consent litigation. Although this may seem counter-productive to the good faith practitioner, it may be a necessary cost of enforcing the societal demand for a fundamental move toward parity in the doctor-patient relationship.

Realistically, disputes over the use of behavior management techniques will occur infrequently. Parents and dentists are not generally in an adversarial posture. Miller[19] suggests that in the few instances where legal action has arisen over the unconsented use of techniques such as HOME, the problem really has been one of poor parent management. The pediatric dentist who is sympathetic to parental concerns and takes time to address them before proceeding with treatment will serve to enhance rapport and to cultivate a feeling of trust.[29] Ultimately, the best defense for potential disputes is to prevent them from arising in the first place.

Conclusions

Presently, the law on informed consent is in a state of flux. The prudent dental practioner treating child patients would be well advised to obtain express parental consent for any aspect of treatment that might be considered significant or objectionable to the average parent. Results of a recent study indicate that several nonpharmocologic behavior management techniques fall into this category. These include use of HOME, restraining devices, and physical restraint by dental personnel.

The authors acknowledge Dr. David Nash for editing assistance, Mrs. Georgeann Dunko-Nine and Mrs. Jane Womble for manu-

script preparation, and Messrs. Peter Bedick and Warren McCollum for illustrations.

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Statement of Ownership, Management, and Circulation

Pediatric Dentistry, The Journal of the American Academy of Pediatric Dentistry, is published quarterly by the American Academy of Pediatric Dentistry, 211 E. Chicago Ave., Suite 1036; Chicago, IL 60611. Editor in Chief: Ralph E. McDonald, DDS, MS, University of Indiana School of Dentistry, 1121 W. Michigan; Indianapolis, IN 46202. Managing Editor: John B. Ferguson, 1411 Hollywood Blvd.; Iowa City, IA 52240.

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