



# Informed consent in pediatric dentistry: a comprehensive overview

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In recent years, pediatric dentists and other health care providers have developed a greater interest in the issue of informed consent largely due to an increase in malpractice litigation and the ever-escalating cost of liability insurance. In order to ensure self-protection and/or thwart a lawsuit, it is essential that the medical/dental practitioner fully understand the basic concept of informed consent, and incorporate its principles in providing treatment to patients.

## The concept of informed consent

“Consent is willingness in fact for conduct to occur. It may be manifested by action or inaction....”<sup>1</sup> Consent as used here refers to a patient’s authorization to be treated by a physician or other health care provider. Consent may be either expressed (spoken or written) or implied by inference from a patient’s conduct.<sup>2</sup>

“Informed consent is most clearly defined in guidelines on consent to medical research, not to treatment.”<sup>3</sup> The Nuremberg Code, established in 1947, mandates “that ‘there should be made known’ to each research subject: ‘the nature, duration and purpose’ of the intervention; ‘the method and means by which it is to be conducted; all conveniences and hazards reasonably to be expected; the effects upon his health or person which may possibly come’; and the ‘liberty’ to withdraw ‘if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible’.”<sup>4</sup>

In addition, the 1964 Declaration of Helsinki states “that potential subjects should be informed of: ‘anticipated benefits’; and their ‘liberty’ to refuse to take part.”<sup>5</sup>

The informed consent doctrine serves primarily to protect a patient’s right of self-determination, and to allow a patient the freedom to determine what should be done with one’s body.<sup>6</sup> Professor Alexander Capron, however, insists that “the doctrine can serve six salutary functions. It can:

1. Protect individual autonomy
2. Protect the patient’s status as a human being
3. Avoid fraud or duress
4. Encourage doctors to carefully consider their decisions
5. Foster rational decision-making by the patient and
6. Involve the public generally in medicine.”<sup>7</sup>

“The legal standard for informed consent to medical treatment requires that the consentor be informed, competent, and acting voluntarily.”<sup>8</sup>

A patient, untrained in medical science, relies on the physician to provide necessary information from which to make a decision to accept or decline medical treatment.<sup>9</sup> The doctor/patient relationship may be viewed as a fiduciary relationship in which the patient has placed trust in the doctor to act in good faith, and in the patient’s best interest.<sup>10</sup> However, it may also be characterized as a dominate/subordinate relationship.<sup>11</sup>

“If a surgeon obtains a patient’s consent to an operation without informing him of the nature of the operation or the extent of the harm that is necessarily involved, the patient’s consent is held not [to] be an ‘informed consent.’”<sup>12</sup>

The informed consent doctrine stipulates that a health care professional has a duty to disclose all relevant information about a patient’s condition, the recommended treatment of that condition, the treatment alternatives (including no treatment), along with the risks and benefits associated with the proposed treatment and the treatment alternatives. However, there are two recognized exceptions to this doctrine — emergency and therapeutic privilege.

In an emergency situation, when a patient is incapable of giving consent and prompt medical treatment is required, there is generally no duty to obtain informed consent.<sup>13</sup> Also, if the patient is exceptionally high-strung or unstable, and the physician reasonably believes full disclosure would be detrimental to the patient’s well-being, a therapeutic privilege may exist.<sup>14</sup>

Some courts have recognized other circumstances negating the need for informed consent. If a patient is incapable of giving consent; i.e., under general anesthesia, and no one is immediately available to consent for the patient, a physician may not need to obtain informed consent to extend an operation to remedy an abnormal or diseased condition in the area of the original incision.<sup>15</sup> Also, it may not be necessary for a physician to disclose an obvious risk that is or should be common knowledge to the patient.<sup>16</sup> In addition, it may be unnecessary for a physician to disclose a risk that is not reasonably foreseeable,<sup>17</sup> or one not known to a physician who has exercised ordinary care.<sup>18</sup> Furthermore, a physician need not disclose the risks of a proce-

sure if the patient has specifically requested not to be informed of such risks.<sup>19</sup>

The first court to recognize and deal with informed consent was *William Twombly and wife v John T. G. Leach*.<sup>20</sup> In this 1853 case, Mrs. Twombly declared that had she known the risk associated with a thumb lancing procedure, she would not have allowed it to be performed. The court held that "whether it be good medical practice to withhold from a patient in a particular emergency, or under given or supposed circumstances, a knowledge of the extent and danger of his disease, the testimony of educated and experienced medical practitioners is material and peculiarly appropriate."<sup>21</sup>

In *Salgo v Leland Stanford, Jr., University Board of Trustees*,<sup>22</sup> the California Court of Appeals found that a physician has a duty to disclose "any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."<sup>23</sup> The court also held that a patient must understand the procedure to which that patient has consented or the consent is invalid.

It should be noted that the disclosure of a general risk, such as death, does not discharge the duty to disclose specific risks. If such an undifferentiated warning were "found to satisfy the duty to warn...then the duty to warn would become very hollow indeed."<sup>24</sup>

### Battery versus negligence

A failure to obtain informed consent may result in litigation based on the legal concepts of negligence and/or battery. A claim founded on negligence is substantially different from one founded on battery. Negligence occurs when the conduct of a health care provider falls below the accepted standard of care, resulting in injury to the patient. Battery, however, occurs when there is an injury to one's dignity.<sup>25</sup>

The major distinctions between negligence and battery are the types of damages that may be allowed and the restraints imposed by the statutes of limitations. Also, a battery may be actionable as a tort (civil) or a criminal law violation, whereas negligence is actionable only under tort law. The prevailing view is that an action on the issue of informed consent is one of negligence rather than battery; however, the theory of battery has not been put to rest. It should be noted that an action for both battery and negligence may be brought simultaneously. Also, for a battery action, expert testimony is not required.<sup>26</sup> In addition, professional liability insurance may not cover intentional torts or criminal actions.

Earlier cases involving medical treatment without informed consent were based on the concept of battery. In *Schloendorff v Society of New York Hospital*,<sup>27</sup> Judge Benjamin Cardozo stated:

*In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body;*

*and a surgeon who performs an operation without the patient's consent commits an assault for which he is liable in damages.*<sup>28</sup>

In *Cobbs v Grant*, the court held that a battery should be considered when treatment is done without consent; however, negligence should be considered when the doctor fails to disclose pertinent information to the patient.<sup>29</sup> This idea was advanced in *Logan v Greenwich Hospital Association*,<sup>30</sup> a 1983 case which held that:

*[t]he theory of battery as a basis for recovery against a physician has generally been limited to situations where he fails to obtain any consent to the particular treatment, or performs a different procedure from the one for which consent has been given....*<sup>31</sup>

Although battery was a consideration, this case was tried under the theory of negligence since the physician failed to adequately disclose the treatment alternatives to the patient.

### Professional versus lay standard

Once a duty to provide informed consent exists, the next question is to determine the disclosure standards or the judicial treatment of the adequacy of the disclosure.

The two major standards existing today are the professional medical standard (traditional standard), and the lay standard (material risk or prudent patient standard). The professional standard requires the doctor to disclose those risks that a reasonable medical practitioner of similar training would disclose under like conditions. The lay standard requires the disclosure to be determined by the patient's need for information as considered material to the decision to accept or decline treatment.

The professional standard was basically the industry test as stated in *Natanson v Kline*,<sup>32</sup> however, a trilogy of landmark cases decided in 1972, abandoned the professional in favor of the lay standard. This trilogy of cases included *Canterbury v Spence*,<sup>33</sup> *Cobbs v Grant*,<sup>34</sup> and *Wilkinson v Vessey*.<sup>35</sup> Although the formulation of the standard of disclosure varies in each case, they all reject the professional standard and establish the lay standard of informed consent.

In *Hook v Rothstein*,<sup>36</sup> a 1984 case, the court, considering both the professional and lay standard, held "the better standard is the professional standard."<sup>37</sup> The court reasoned that the basic principle underlying every medical malpractice action was a deviation from the standard of reasonable medical care.

Many states have enacted statutes dealing with informed consent, with the majority adhering to the professional standard. Some statutes merely restate the case law, while others establish that if a signed consent is obtained that meets the conditions of the statute, there is a presumption that the patient has been properly informed.<sup>38</sup>

## Expert testimony

In jurisdictions that adhere to the professional standard of informed consent, courts have uniformly held that expert medical testimony is required to establish both the existence of a duty to disclose and a deviation from the standard of care.<sup>39</sup> However, in jurisdictions that apply the lay standard, expert testimony may not be necessary to establish the existence or the extent of a duty to provide informed consent.<sup>40</sup>

## The element of causation

Even though a health care provider fails in the duty to disclose material information, damages are not automatically recoverable under the theory of negligence. An adequate nexus between the causation and the resulting harm must be shown. It must be clearly demonstrated that the patient and/or a reasonable person would not have undergone the procedure had the material risks been known.

The element of causation varies in different jurisdictions. Some jurisdictions use the subjective test, which requires the patient to establish that the procedure would not have been undergone had the risks been properly disclosed.<sup>41</sup> Other jurisdictions use the objective test, which requires showing that a reasonable person would not have undergone the procedure had disclosure been adequate.<sup>42</sup> Still, other jurisdictions require establishing that neither the patient nor a reasonable person would have undergone the procedure had the risks been adequately disclosed.<sup>43</sup>

## Informed consent for minor children

The question of who may provide informed consent for the medical/dental treatment of a minor may be somewhat confusing. Is it the parent/legal guardian, the child, or the state?

At common law, children were given no powers or rights of their own. As a child's primary caretaker, the parents were entrusted to make decisions in the child's best interest. This was not only a duty, but an element of the parents' right to rear the child as they deemed necessary and appropriate. Considered fundamental, this right was not absolute. The state, as *parens patriae*, could interfere when necessary to protect society at large, as well as the health and well-being of the child.<sup>44</sup>

Without addressing the specifics of state versus parental rights with respect to providing informed consent for the medical/dental treatment of a minor, it should be noted that family autonomy is not absolute, and that parental decisions that might jeopardize the safety and/or health of a child may justify state intervention.<sup>45</sup>

An example of state intervention is clearly demonstrated by the utilization of compulsory vaccination laws.<sup>46</sup> In *Jacobson v Massachusetts*,<sup>47</sup> the US Supreme Court held that a state may impose a compulsory smallpox vaccination law as a "reasonable and proper exercise of police power."<sup>48</sup> Such intervention by the state

may totally abrogate the concept of informed consent. *Bouvia v Superior Court*<sup>49</sup> and similar cases have trifled with this idea.

The general rule, as numerous courts have held, is that informed consent for the medical/dental treatment of a child is to be provided by the parent.<sup>50</sup> This type of consent is known as informed proxy consent or substituted judgment.

*The Random House Dictionary* defines proxy as "an ally or confederate who can be relied upon to speak or act in one's behalf."<sup>51</sup> Another form of proxy consent may be established when a patient allows the treatment decision to be made by the practitioner.<sup>52</sup> This, in effect, is a waiver of the patient's right to informed consent.

When proxy consent is given by a parent for a child, it involves the parental understanding of the nature and purpose of a proposed medical treatment, the risks and benefits, as well as the treatment alternatives.<sup>53</sup> Proxy consent is at its highest level of effectiveness when the child understands and agrees with the parent as to the method of treatment to be provided.<sup>54</sup>

There are two well-recognized common law exceptions to the general rule requiring parental consent. These are the emancipation exception<sup>55</sup> and the mature minor exception.<sup>56</sup> "Most states have laws establishing that minors may give consent for their treatment under specific conditions."<sup>57</sup>

A child's consent may be effective if the child is "capable of appreciating the nature, extent and probable consequences of the conduct consented to, although the consent of a parent, guardian or other person responsible is not obtained or is expressly refused."<sup>58</sup>

One of the first cases to comment on a child's right to consent to a surgical procedure was *In re Siefert*.<sup>59</sup> This 1955 case dealt with the surgical correction of a cleft lip and palate on a 14-year-old male. The court held that the parental wishes to decline the surgical correction could not be overridden by the state as no emergency existed. However, the trial court stated that had the child wanted the surgery, the judge would have ordered it.

## Consent for dental treatment

Consent for dental as well as medical treatment may be established by inference from a patient's actions. For example, in *O'Brien v Cunard Steamship Co*,<sup>60</sup> the plaintiff, in compliance with quarantine laws, stood in line awaiting vaccination; she observed others being vaccinated, held up her arm and made no objections, and then accepted her certificate of vaccination. The court held that the plaintiff's conduct provided implied consent to the vaccination.

As in the *O'Brien* case, implied consent may be provided by a patient who enters the dental office, completes the pretreatment forms, sits in the dental chair, and allows a procedure to be performed.<sup>61</sup> However, in today's litigious society, implied consent may not provide adequate protection for the dental practitioner.

In the past, the most frequent cause for dental litigation, with respect to informed consent, has been insufficient disclosure of the risks associated with dental extractions.<sup>62</sup> However, with the field of dentistry rapidly expanding and becoming more complex, a greater need for expressed informed consent has been created. As modern scientific studies and upgraded treatment modalities, and new and improved materials are constantly surfacing, the patient has an increased need for relevant information regarding these advances.

The news media and such programs as *20/20*, and *60 Minutes* have brought public attention to some of these advancements and the existing controversies in the field of dentistry. These include such topics as infection control (Kimberly Bergalis), sedation/anesthesia in the dental setting, dental materials with special emphasis on endodontic (Sargentii) and restorative (amalgam) filling materials, as well as other issues.

One potential problem dealing with the lack of informed consent in dentistry is the questionable safety of some of the materials and/or medicaments used in dental procedures. For years, considerable controversy has centered around such substances as mercury-containing amalgam filling material, formocresol, composite filling material, fluoride, and others.

The use of these dental materials characteristically has been decided by the dental practitioner. However, with the recent focus on many of these substances and the newer research findings, "[i]t would be...better to inform the patient of the possibility of alternate... materials...if appropriate, with the patient being told of the advantages and disadvantages"<sup>63</sup> of each. It seems only reasonable that the patient be adequately enlightened in order to make informed treatment decisions.

### **Pediatric dentistry**

The dental treatment of a child may be provided by any licensed dental practitioner; however, the pediatric dental specialist is "dedicated to meeting the unique dental health needs of all children."<sup>64</sup>

The issue of informed consent is critical to the relationship among all parties involved. The clinical approach to providing and obtaining adequate informed consent should be consistent. "It is now conventional wisdom... [to] employ a standard procedure for informing patients of the risk"<sup>65</sup> of pediatric dental care. If a dental practitioner can demonstrate the habit of including the use of a standard informed consent protocol that clearly provides information regarding the material risks attendant with dental procedures, a court of law will be more inclined to find that actual consent was provided.

Obtaining informed consent to treat a pediatric dental patient generally requires the practitioner to obtain proxy consent from the child's parent, as the child is typically incapable of granting such consent.<sup>66</sup> It is felt that proxy consent should not be confined to major

procedures, but should include low-risk dental procedures as well.<sup>67</sup>

The task of obtaining informed consent should not be delegated to an auxiliary, but should be that of the pediatric dentist. The informed consent process should be unambiguous and free of medical terminology in order to be easily understood by a parent. Although verbal consent may satisfy legal requirements, written consent provides more adequate documentation should any questions arise. It is well recognized though, that "a written consent isn't worth the paper it is printed on if, after reading it, the patient hasn't been informed!"<sup>68</sup>

If oral consent is obtained, it should be witnessed and documented in the patient's chart. This documentation is essential as parents "may not recall or recognize information given to them as part of the informed consent process."<sup>69</sup> This is particularly true after substantial time has elapsed or during emergency situations.

Since dental treatment often is ongoing, it may not be necessary to obtain specific informed consent for every procedure. A general consent, expressed or implied, may be adequate for routine dental procedures. An example of such consent may read as follows:

*I hereby give permission to Dr. \_\_\_\_\_ to provide routine dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not be limited to, topical anesthetic, voice control, intermittent radiographs, local anesthetics (injections), etc.*

However, for procedures that are not routine, specific consent should be obtained.

The parent or consent giver should be encouraged to ask questions, and the pediatric dentist should provide complete and honest answers. It should be made explicitly clear "that the treatment has no absolute guarantees or warranties."<sup>70</sup> For the more complicated procedures, "an excellent supportive action is to seek a second opinion on the proposed treatment."<sup>71</sup>

### **Consent for behavioral management**

The child who refuses or is incapable (mentally or physically impaired) of accepting the treatment to which the parent has given informed proxy consent may require certain behavior management techniques for which specific consent should be obtained. This class of pediatric patients may prove to be the most challenging to the dental care provider.

When tender-loving-care fails, managing a pediatric dental patient may become an issue equal or superior to the proposed treatment itself. The dental practitioner should refer the patient to an appropriate specialist if incapable of managing the child.

The American Academy of Pediatric Dentistry (AAPD) has established guidelines for the dental treatment of children. (The 1988 subcommittee

report on informed consent may be obtained upon request.) AAPD's *Standards of Care for Behavior Management*, include: communicative management, conscious sedation, general anesthesia, hand-over-mouth technique, nitrous oxide-oxygen inhalation sedation and physical restraint."<sup>72</sup>

The basic treatment goal of the pediatric dental practitioner is "to treat the child in the most efficient manner, that is, efficiency for the child, the doctor, and the staff; with the least amount of trauma to the child, rather than the least amount for the dentist or for the parents."<sup>73</sup>

Recent studies indicate that informed parents show a higher level of approval of behavior management techniques than do uninformed parents.<sup>74</sup> Although communicative management techniques, such as tell-show-do, voice control, etc., are low-risk procedures that legally may require no specific consent prior to their use, many parents will become upset if not informed of their purpose.<sup>75</sup> When this technique is unsuccessful, the health care provider may wish to consider using chemical restraints, physical restraints, or a combination of both.

The decision to use chemical or physical restraints on a pediatric dental patient requires careful consideration. Selecting a treatment modality should be based upon one or more of the following factors:

1. The child's behavior
2. Amount of treatment needed
3. The child's medical and physical condition
4. Number of visits required
5. Distance traveled to the office
6. The child's ability to learn (IQ)
7. The child's age
8. Inpatient vs. outpatient treatment
9. Financial considerations
10. Availability of facilities
11. Trauma of hospital visit
12. Anesthetic risk<sup>76</sup>
13. Other pertinent factors.

Chemical restraints involve the use of various types of pharmacological agents, which range in effectiveness from relative analgesia to general anesthesia. A deeper sedation creates a greater risk to the child. Consequently, there is an increased need to obtain specific consent from the parent. Physical restraints, on the other hand, are relatively low-risk procedures used commonly in the dental setting, as well as in hospital emergency rooms.

The office use of chemical restraints such as nitrous oxide analgesia, conscious sedation, and/or general anesthesia, requires an adequately trained dentist and staff and a properly equipped facility. Specific informed

consent should be obtained before initiating these treatment modalities.

The use of chemical restraints for dental care in a hospital setting may be under the domain of an anesthesiology department. Most frequently, hospital general anesthesia is provided by oral intubation or by placing and maintaining an airway tube through a patient's mouth. Since this tube further restricts an already confined working area, many dentists prefer to have the airway tube placed through the nasal cavity instead. This nasal placement increases the risk involved in the general anesthesia, as nasal mucosa or lymphatic tissue occasionally will be torn, causing hemorrhage. If nasoendotracheal intubation is indicated, it may be wise for the dental practitioner to acquire specific consent in addition to that obtained by the anesthesiologist.

With the increased cost of professional liability insurance, especially for chemical restraint techniques such as parenteral sedation and/or general anesthesia, physical restraining techniques, which have a much lower risk factor, are again becoming more routine.

Physical restraints may seem barbaric to the uninformed parent, but this type of behavior management is far less invasive than most forms of chemical restraints. Physical restraints may consist of auxiliary personnel simply holding a child's arms and/or legs. Many practitioners prefer to use commercial devices such as the Pedi-Wrap or the Papoose Board as they are more effective and reduce the possibility of marks and/or bruises on the child. All restraint methods "should be designed to cause no physical injury and the least possible discomfort,"<sup>77</sup> to the patient. During physical restraint use the practitioner must, at all times, maintain self-composure, and should continue to use communicative management techniques with the child.

Other physical restraint methods are the hand-over-mouth (HOM) and the hand-over-mouth with airway restricted (HOMAR) techniques. The HOM technique is currently being taught and used in approximately 80% of the advanced educational pediatric dental programs to control a child's hysterical or tantrum-like behavior. These programs generally "agree that the negative psychological effects of HOM are nonexistent or minimal."<sup>78</sup> The HOMAR technique is used only in 11% of these programs, and appears to be passing out of existence.<sup>79</sup>

*The proper application of the HOM technique is essential and is described as follows: The child is placed firmly in the dental chair. If the child flails his arms and legs, the dentist and dental auxiliary will restrain the child to prevent self-harm and damage to the dental staff and equipment. If the dentist cannot communicate with the child because the child is screaming and crying, the dentist may then place his hand over the child's mouth to stifle the noise. Simultaneously the dentist says calmly and firmly, but without anger, 'You must stop crying.'<sup>80</sup>*

This technique is generally not employed in the presence of a physical or emotional handicap, or with a child too young to communicate with a dentist. However, for a child who resorts to tantrums, hysteria, etc., HOM is an excellent method of obtaining the child's immediate cooperation, as well as modifying behavior for future visits.

Since the HOM technique has not been tested in the legal system, prior consent is suggested. Some authorities contend, however, that specific consent for this procedure is unnecessary because general consent to provide pediatric dental care is all-inclusive.<sup>81</sup> Although this contention may have merit in jurisdictions following the professional standard for informed consent, other authorities recommend that prior to providing any dental treatment for a minor patient, a written general consent should be obtained. They further recommend, that before using physical restraints, an additional oral consent should be given by the parent that is witnessed and documented by a staff member. Also, a specific written consent should be signed by the parent, witnessed by a staff member, and "should be clearly labeled as a 'Consent for the Use of Physical Restraint.'"<sup>82</sup> These recommendations provide the practitioner with three types of informed consent, and should prove to be a strong defense against a potential litigation.<sup>83</sup>

The dental practitioner "must carefully judge each patient each time, and rejudge each patient each new time, to be sure that evidence of their [sic] capacity to participate is not overlooked."<sup>84</sup> One of the desired goals is to decrease and/or eliminate chemical and physical restraining techniques as soon as possible. If a patient's "behavior improves with good use of behavior modifying techniques, the need for restraints and sedation diminishes or even disappears."<sup>85</sup>

At this time, the American Academy of Pediatric Dentistry does not endorse any specific standardized forms to be used for informed consent. "Given the unsettled state of the law on this subject, and the fact that informed consent doctrine varies in its technicalities from one jurisdiction to another, it is not possible to develop an all-purpose form of guaranteed efficacy."<sup>86</sup> However, upon request, the AAPD provides its members with copies of forms that have been developed as the result of a joint effort by the Louisiana State University School of Dentistry Department of Pediatric Dentistry, the Louisiana Academy of Pediatric Dentistry, and the Clinical Affairs Committee of the AAPD. The following forms are available:

1. *Pediatric Dentistry Consent for Dental Procedure and Acknowledgment of Receipt of Information*
2. *Pediatric Dentistry Informed Consent for Patient Management Techniques and Acknowledgment of Receipt of Information*
3. *Consent for the Use of Sedation or General Anesthesia for Pediatric Dental Treatment and Acknowledgment of Receipt of Information*

#### 4. *Orthodontic Treatment Informed Consent and Acknowledgment of Receipt of Information.*

The AAPD stresses that these forms have not been approved by the Academy. They are intended to be used only as guidelines in compiling individualized forms designed to meet the particular needs of the dental practitioner.

## Conclusion

The doctrine of informed consent should be an integral aspect of all pediatric dental procedures. The results of a 1990 survey of AAPD members indicated that more than 70% of respondents did not know "the correct standard governing informed consent in their state."<sup>87</sup> As "the issue of informed consent comes up, in one form or other, in virtually every dental malpractice case,"<sup>88</sup> the prudent pediatric dentist should be aware of the benefits of obtaining proper consent. Such benefits are included in the following:

*First, well-informed patients who understand the nature of the problem and have realistic expectations are less likely to sue. Second, a properly presented and documented informed consent often prevents unmeritorious claims based on misunderstanding or unrealistic expectations of the patient. Finally, obtaining an informed consent offers the dentist the opportunity to develop better rapport with the patient by demonstrating a greater personal interest in the patient's understanding of the problem and anticipated treatment.<sup>89</sup>*

The parent, when bringing the child to the dental office, may be implying general consent for ordinary dental care; however, specific written consent is highly recommended for all procedures, especially those not considered routine.

After a thorough discussion of the diagnosis, the proposed treatment, the treatment alternatives (including no treatment), and the risks and benefits associated with each, the pediatric dentist should obtain the parent's signature verifying that such information was given, and was understood. This procedure should be witnessed by a third party such as a dental assistant. The practitioner should also obtain the signature of the witness, verifying the informed consent procedure, including the parent's signature.

The pediatric dentist "should view informed consent as a means of helping the patient, not merely as a legal obligation, and conversely, should not use the consent form as a shortcut to patient discussion and communication."<sup>90</sup> Practical tips regarding the issue of informed consent for the pediatric dentist are as follows:

1. **Communicate** with the parent/patient — good rapport is the most important aspect of the doctor/patient relationship.

2. **Document** the parent's/patient's consent in the medical/dental records in writing with as much detail as possible.
3. Have the parent/patient **sign** the consent form and have it properly **witnessed**.
4. View informed consent as a means of providing **beneficial information** to the parent/patient, not merely as a legal obligation.
5. **Perform your own consent consultation** rather than relying upon another doctor or an assistant.
6. Use **lay terms**.
7. Be **forthright** without causing undue anxiety.
8. Fully discuss the **risks, benefits, and alternatives** with the parent/patient, rather than relying upon the form itself.
9. **Know your state's statutes and regulations** concerning informed consent.<sup>91</sup>
10. Be aware of the extent of your **liability insurance coverage**; intentional torts and criminal actions (battery) generally are not covered.
11. Contact the **AAPD for guidelines** regarding informed consent.
12. Develop an **individualized informed consent protocol** designed to meet the particular needs of your practice.

Since individual states have the authority to define what constitutes informed consent by decisional law or statutory enactments, the pediatric dentist is strongly advised to consult with an attorney, the state or local dental association, and/or the State Board of Dental Examiners prior to establishing an office policy concerning informed consent. "The prudent practitioner is well advised to pursue a course of practice which will satisfy the most rigorous informed consent scenario."<sup>92</sup>

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*From the Archives*

## And you don't even need a pulse oximeter

Professor Redard and Professor Emery of Geneva have discovered a new anesthetic for use in dentistry. Experiments to learn the effects of colored lights upon the nerves revealed that blue light is extraordinarily soothing. A patient was put in a dark room and his

eyes were exposed to a sixteen-candle blue light for three minutes. This caused him to lose the sense of pain and the tooth was then painlessly extracted without the aftereffects of ether or chloroform.

*The Dental Summary, 1904*