Informed Consent in Oral Surgery

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In my last article (Dentaltown, March 2009, “Think Like an Oral Surgeon”), I discussed some fundamental principles that you need to consider when contemplating performing dentoalveolar surgery in your practice. In this article, I will cover another important topic for consideration before you begin surgery – Informed Consent.

There seems to be a lot of confusion on the exact meaning of this term. Informed Consent is not the form that you have patients sign before you do a procedure. Rather, it is the discussion process you have with patients before they give you permission to treat them. The signature on the form is merely a written documentation of this discussion. The specifics of the process can vary, depending on the surgical procedure to be performed, but it is basically a discussion of the patient’s diagnosis and the risks, complications and benefits of the procedure to treat it, as well as any alternative treatments, including the risk of not having the recommended treatment. This does not have to include every possible risk and complication, no matter how uncommon, but should include those that are most common and those that a reasonable patient would want to be informed of, in order to make a rational decision about the treatment you are recommending.

For oral surgery, I like to break down these items into three categories: the common, expected side-effects of the surgical procedure that most patients experience to variable degrees; minor complications that may require some treatment; and those uncommon sequelae that would definitely be considered significant complications of surgery. Those in the first category include bleeding, swelling, pain, and decreased jaw range of motion. The second category includes minor infection, dry socket, bony sequestration, the need to leave an ankylosed root tip, damage to adjacent teeth and restorations and reaction to any medications given. These are all fortunately, for the most part, minor annoyances that will resolve spontaneously or with minor treatment and do not leave the patient with any residual defect. The pertinent more significant risks to discuss are injury to the mandibular or lingual nerve, development of an oral-antral fistula, loss of a tooth root in to the sinus or out the lingual plate of the mandible, mandible fracture and osteomyelitis. These complications may necessitate more involved secondary surgeries to correct, create increased morbidity for the patient, and have possible permanent effects.

In addition, the patient should be given the option of being referred to a specialist for treatment. Even though you might be very competent and comfortable with the procedure, and it might not be practical to have the patient see the specialist, this option should still be discussed. This is especially true for a more complicated procedure, one on a patient with medical considerations, or a procedure that would best be done under general anesthesia. In the unfortunate event of an adverse outcome, having discussed this option with the patient could certainly benefit your defense.

Options, Options, Options

With the success of dental implants in the past 10 years, a more recent development in the medico-legal arena are lawsuits against dentists for failure to advise patients on their options for replacing a tooth (or teeth) following extraction. These patients were treated with fixed and removable prostheses that soon failed, resulting in the extraction of more teeth and loss of bone due to infection, surgery and resorption to the point that these patients became dental cripples. These patents needed extensive bone grafting and other
reconstructive procedures in order to have their dental function restored. They alleged that had they known they could have had dental implants to replace the extracted teeth initially, all of their subsequent restorative failures could have been avoided. Most of these suits were decided in favor of the plaintiffs. They had a very valid position. Today, the long-term success of an implant-supported crown is much better than a bridge abutting on natural teeth. Even if the proposed abutment teeth already have restorations, every time teeth are touched, their longevity is compromised. Therefore, another issue to be discussed in the Informed Consent process is that of the patient’s options for replacement of the tooth being extracted. The advantages and disadvantages of a fixed prosthesis, a removable prosthesis and an implant-supported prosthesis should be covered, as well as the option of doing nothing. If bone grafting and ridge preservation procedures at the time of extraction would be appropriate, to prepare the site for an implant, then this should also be discussed with the patient. To assist in this process in my practice, I developed an informational brochure that we provide to our patients and to our referring dentists, so that when patients present to my office for consultation, they arrive educated about what we will be discussing. That brochure can be downloaded from my Web site at http://www.onlineoralsurgery.com/Videodisplay/Downloads.asp.

**Informed Refusal**

Occasionally, we come across a patient who refuses a treatment that the doctor feels is necessary. Sometimes failure to have the recommended procedure may have life- or health-threatening consequences. When this is the case, the prudent practitioner will thoroughly document this discussion in the patient’s chart, and in addition, will have the patient sign an Informed Refusal form. This memorializes that patients have been informed of all the possible consequences of their decision, and that they still refuse the recommended treatment. It states that the patient should still return for periodic monitoring of their condition, and that the patient has the right and ability to reconsider their decision at any time.

**Requirements**

The Informed Consent document can vary in its length and detail, as long as it covers the above requirements. Some practitioners have a very simplistic form, and others have one that is very detailed. The form I use in my practice is somewhere in the middle. It lists the 16 most common or significant risks and complications, and then has a short paragraph explaining each in terms the patient can understand. There is also language giving the doctor permission to treat any complication, which could arise during the performance of surgery, without obtaining an additional consent, and to send excised tissue for biopsy if you feel that it is clinically indicated. It also includes a statement that there is no guarantee of clinical outcome, the patient has disclosed to you all medically-pertinent information, that they understand what is on the form, and that they read and write English (or whatever language the consent process was conducted in). The patient should also be given the opportunity to ask any questions that they might have about the procedure, or their treatment, in general.

Not only is thorough Informed Consent required from a medico-legal standpoint, it is also good patient care. A patient who is well informed about what to expect after surgery almost always does better. Patients who have been well-educated about why they are having surgery, what is normal and what is not normal in the postoperative period, and what the expected outcome of the procedure is to be, tend to call the surgeon less for “normal” complaints, and will notify the surgeon sooner for significant problems, allowing them to be managed earlier and more effectively. They also tend to have fewer unrealistic expectations of the final result of surgery. The effect is a happier patient and a happier doctor.