Dominic Stannard

# Demonstrating patient consent



**Dominic Stannard is the solicitor responsible for overseeing the management of dental claims for members and knows exactly how the dental record can be used to demonstrate that the patient has provided valid consent to dental treatment**

Most dentists would probably be surprised at the number of civil claims for compensation that we deal with at Dental Protection Limited (DPL). Although being sued by a patient is still a relatively rare occurrence, the last 15 years has seen an explosion in the number of patients willing to approach solicitors to seek compensation for actual or perceived poor treatment from their dentists.

A measure of just how quickly the industry has developed to sue a dentist can be judged by the number of lawyers that we currently employ in-house to deal with an ever-increasing number of dental claims. As little as ten years ago, DPL had just two in-house lawyers to deal specifically with dental claims – today that number has risen to eight full-time in house lawyers, plus supporting staff. The number of new dental claims that we are currently seeing, averages ten new cases a day with the total expenditure on UK claims running well in excess of £30 million. The largest single component of this is - perhaps surprisingly - not the damages paid to the injured patients, but the legal costs paid to the lawyers representing them. As well as causing a significant amount of stress to those dentists involved, the very significant cost of dealing with claims that is incurred by DPL is also reflected in the ever-increasing cost of your annual subscription.

## The time that it takes to make a good clinical note will be more than repaid by avoiding the stress, problems and expense that can all too easily flow from not doing so

One of the issues that arises time after time within claims for compensation are allegations by patients' solicitors that the dentist did not obtain valid consent from the patient for the treatment that was provided. This allegation can be very difficult to defend because the defence of the claim will rely upon precisely what is recorded in the contemporaneous record made by the dentist. This is especially important where the events in question occurred several years before the claim came to fruition, by which time the dentist's memory will inevitably have faded. The difficulties in this regard are compounded by the fact that the patient usually has (or at least claims to have) a good recollection of the events and that the sympathies of the courts will often lie with the patient, sometimes assisted by a lurid description of 'the facts'.

In very simple terms, in order to show that a patient has provided valid consent for any given treatment, the records must show that there has been a full and accurate clinical assessment, that the full range of (reasonable) treatment options has been considered and discussed and that the pros and cons of each treatment option have been given (including potential risks and cost) thereby enabling the patient to be seen to have made an informed decision – simply noting that a patient has agreed to treatment (even with a signed consent form) is not sufficient to demonstrate that the patient has been properly informed and that valid consent has been obtained.

When confronting a new claim, the content of the records that you have made will be of critical and fundamental importance. DPL's in-house legal advisory team (consisting of one of our lawyers and one of our clinically qualified dento-legal advisers) has to consider the prospects for potentially defending a claim based on what the records contain. This is by far the single most important factor in determining whether a patient's claim for compensation is likely to succeed.

We realise that consistently recording the requisite information in the records is in itself a challenging task – quite apart from the amount of information that it is necessary to record within an often hectic working environment, additional demands on your time can result from patients and dentists running late, emergency appointments that have been squeezed in, illness within the dental team or problems with equipment.

Nevertheless, consistently recording the key information for all patient appointments is an exercise that can prove invaluable in the defence against spurious claims. Little can be more frustrating for a dentist than to see a claim having to be settled when the correct advice has been provided but not recorded in the notes. Sadly it is a surprisingly common scenario with significant associated costs.

## A minimum requirement

The record that you make for each and every appointment should contain the necessary information sufficient to demonstrate that the following have been considered:

- the purpose of the appointment and/or details and history of the presenting complaint
- investigations and assessment (eg. clinical examination, radiographs, vitality tests)
- diagnosis (based on the range of appropriate investigations)
- treatment options (including the option of no treatment where appropriate)/advice (including specialist referral).

Consistently providing this basic information within your records is the best line of defence that you have against a future potential claim. Not to do so, means that there is an increased likelihood of claims by your patients (particularly with the present trend for claims showing no signs of diminishing) with all the stress and the calls on your time that a legal challenge can produce. There is also the possibility of the associated poor claims record leading to participation in the risk partnering programme and a higher subscription. Worst of all, however, there is the very real prospect of censure by the GDC when patients (possibly being encouraged by their solicitors to do so) decide to make a complaint to the General Dental Council.