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SCIENTIFIC SECTION

A survey of the consent practices of specialist orthodontic practitioners in the North-West of England

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Objective: To use a questionnaire to obtain information on the consent practices of specialist orthodontic practitioners in the North-West of England and highlight any areas for improvement.

Design: Postal questionnaire.

Setting: This survey was conducted among specialist practitioners in 2005–2006.

Subject and methods: A questionnaire was sent to 84 specialist practitioners on the specialist register in the North-West of England. This consisted of six sections with a mixture of yes/no responses and a section that determined for which subjects consent was obtained and how.

Outcome: Responses were received from 58 (69%) practitioners. Ten were discounted.

Results: Forty-five (94%) of the 48 practitioners who responded routinely obtained consent from patients, and 27 (60%) used a consent form. Of these 27, 16 (59%) forms were based on a recommended design from an organization such as the British Orthodontic Society. Twenty-three (85%) practitioners gave the form to the patient/parent to read themselves, and 24 (89%) got the consent form signed by the patient/parent. Eighteen (67%) forms were countersigned by the orthodontist or an assigned member of staff. Seventeen (63%) practitioners gave the patient a photocopy. Of the 45 respondents who did obtain consent from their patients, seven (16%) practitioners assigned the consent process to a member of staff. Twenty-eight (62%) respondents would allow a patient under 16 to consent to treatment, with the youngest age being 10 years.

Conclusions: Forty-five (94%) specialist practitioners who responded did routinely obtain consent from patients for treatment, but 18 (40%) did not use a consent form. The subjects discussed with the patient varied. Areas for improvement are highlighted.

Key words: Consent, orthodontics, specialist orthodontic practitioner

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Introduction

The issues relating to gaining informed patient consent are important to all clinicians. As has been highlighted recently by Gardner and Jones, medical consent varies not only from country to country but even sometimes from state to state.[1] Recently, there have been wide changes in the way in which patients give their consent for treatment. In the UK, the impetus for this change came in 2000, following the publication of the National Health Service (NHS) Plan, which identified the need for a change and recognized the central importance of the rights of each patient. It aimed to ensure that the process of informed consent focused on the needs of patients and their relatives.[2] Also in 2000, the British Dental Association produced an advice sheet, *Ethics in Dentistry*, which discussed the need for valid consent and its principles.[3] In 2001, the Department of Health also published a guide to consent for the examination or treatment of a patient.[4] This provided advice on English law concerning consent to physical interventions on patients,[5] and was followed in 2002 by a publication providing guidance on the implementation of consent policies and examples of model policies and consent forms.[6]

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The model policy states that valid consent is crucial. For consent to be valid:

- the patient must have the capacity to give consent;
- the patient must be given sufficient information on which to base their decision; and
- that decision must be made voluntarily.

The above documents brought the subject of consent to the attention of both patients and professionals. Consent may be written, verbal or non-verbal. The point of a form is to record the patient's decision. Consent is the process of communicating key information to a patient regarding any proposed treatment, to enable them to come to an informed decision on whether or not to proceed. Their signature on a form is a written record that the process has occurred, but is not in itself consent.[7] However, in dento-legal circles, consent is more concerned with what a patient has understood than with the information that a clinician has provided.[8]

The General Dental Council (GDC) considers this to be an important subject, since in 2005 they produced a series of guidance books, which again reinforced the need for proper consent. *Standards for Dental Professionals*[9] set out principles that should be followed by dental professionals, including respecting patients' dignity and choices. *Principles of Patient Consent*, published in June 2005, goes into this in more detail.[10] It states that it is a general legal and ethical principle that valid consent must be obtained before starting treatment, and explains the principles that must be followed in gaining consent. The other relevant publication from the GDC is *Principles of Dental Team Working*, published in October 2005.[11] As the role of auxiliaries increases in orthodontic practice, it is important that there should be adequate training before the responsibility for obtaining consent is passed to a team member.

Any trust or organization may have a policy in place, setting out how consent is to be obtained. An individual specialist practitioner will have to implement their own system and introduce a practice policy. There is information available from many sources that must be interpreted by the practitioner and incorporated into their day-to-day work. The British Orthodontic Society produces guidelines and model consent forms on which practitioners may base their policy.[7]

Many practitioners now use a form to obtain consent, as although verbal consent is valid, it may be difficult to prove that consent was obtained unless there are well-written notes or a signed form to support this claim.[12]

There are 1660 providers of orthodontic treatment in the UK, of whom 919 are specialists. Of these, 70% work primarily in general dental services or specialist practice, and 26% work in a hospital setting.[13] A survey of the consent practices of consultant orthodontists in the UK, with special consideration of orthognathic surgery, has already been carried out,[1] and recommendations have been made for the consent process in this area. As consent is a very topical and important issue, the authors decided to survey the consent practices of specialist orthodontic practitioners. As the authors are based in the North-West of England, this was chosen as the sample area, with the possibility of extending the survey to cover the whole of the UK in the future.

When discussing treatment with a patient, it is important that sufficient information is given to allow an informed decision to be made regarding consent.

The main discussion points would be the risks and benefits of treatment, the limitations of what can be achieved, and what other options are available (including the effects of doing nothing). The clinician should also be aware that cultural variations also exist. In some countries, patients attending a doctor or dentist still expect the clinician to tell them what treatment they will receive,[8] although such 'medical paternalism' is disappearing. However, with regard to orthodontics, there are several factors that are particularly relevant and that could be discussed with a patient or parent. Orthodontic treatment is a long-term process with a commitment to regular visits. Treatment time will be lengthened if the appliance is repeatedly broken and such problems are not reported. There is a need to maintain an excellent standard of oral hygiene, with the use of fluoride, to avoid damage to the teeth and supporting tissues, and there are necessary dietary restrictions.[14] A well-recognized complication of orthodontic treatment is root resorption, with blunt and pipette-shaped roots showing a greater degree of risk.[15] Traumatized or heavily restored teeth carry a risk of becoming non-vital,[16] and any tooth with a large restoration or a crown could be damaged or fractured during treatment, especially when debonding. Some discomfort will be experienced after bonding of the appliance and after any adjustments.[17] These factors were all included in the questionnaire.

The subject of consent is clearly an important issue and is relevant to all clinicians. It is therefore useful to investigate consent procedures in case, for example, there are any aspects of practice that would benefit from improvement. Our aim was to use a questionnaire to obtain information on the consent practices of specialist orthodontic practitioners in the North-West of England and highlight these areas. Advice was obtained regarding ethical approval. Ethical consent was not required, as this project was in the form of an audit/survey.

Method

A questionnaire was developed and pre-piloted to four local specialist practitioners. The original questionnaire was modified, and the pilot study was sent to 10 specialist orthodontic practitioners outside the North-West. We received eight replies. After further revision, the questionnaire was sent to the 84 specialist orthodontic practitioners in the North-West of England, together with a covering letter and a return stamped addressed envelope. This is shown in the flow chart (Figure 1). The Dental Practice Board (DPB) Dental Review was used to define the North-West,[18] and the practitioners' names were obtained from the GDC specialist list 2005.

The questionnaire was divided into six sections that mainly required yes/no answers. The questionnaire can be seen in Appendix 1.

Section 1 established:

- whether the practitioner worked in hospital or specialist practice;
- whether their work was provided mainly on the NHS or privately;
- whether the practitioner routinely obtained consent from their patients pre-treatment.

If they did obtain consent, respondents were directed to section 2, which listed the most common subjects that could be discussed with a patient. The practitioner was asked to indicate whether each subject was discussed and, if recorded, whether it was part of the patient's notes or on a separate consent form.

These subjects were:

- root resorption
  - always
  - only if there was a root shape which predisposed to resorption;
- commitment to regular visits;
- length of treatment time;
- maintenance of good oral hygiene;
- use of fluoride mouthwash;
- dietary restrictions;
- avoidance of fizzy/acidic drinks;
- risk of decalcification;
- risk of devitalization of traumatized/heavily restored teeth;
- fracture risk to any crowns/large restorations;
- discomfort after fitting/adjustments;
- reporting of any breakages;
- risk of failure to complete treatment;
- need to wear retainers post-treatment;
- risk of relapse;

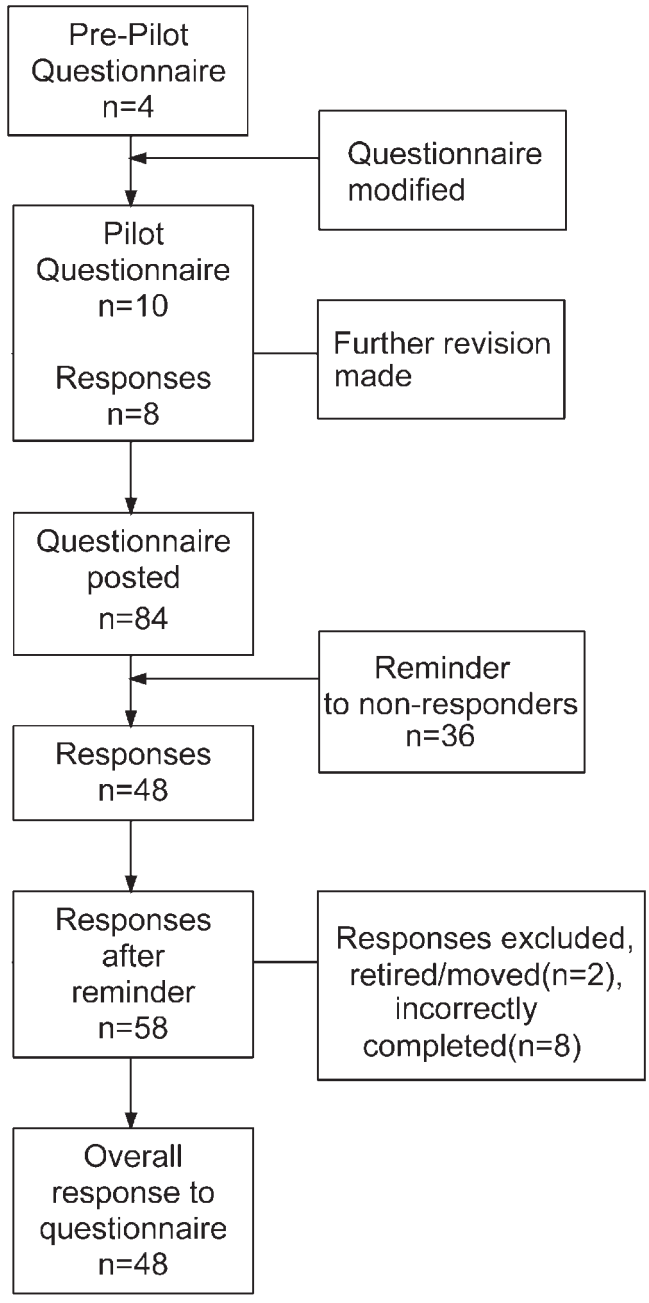

Figure 1 Flow chart showing the production of the questionnaire and related response rates

- benefits of treatment;
- an option to detail any other subjects discussed.

If a form was used, section 3 asked for details such as:

- its design;
- whether it was signed by the patient/parent;
- whether it was countersigned by the practitioner;
- whether a copy was given to the patient/parent.

A copy of any form used to obtain consent was requested.

Section 4 asked all practitioners obtaining consent who was actually responsible for obtaining the consent, themselves or a member of staff.

As many orthodontic patients are under 16 years old, section 5 asked what would be the youngest age at which a practitioner would consider accepting consent, providing that the patient was Gillick competent.[19,20] This term was coined following the case of Gillick v. West Norfolk and Wisbech Area Health Authority in 1985, when the House of Lords established the Fraser guidelines:

- A child under 16 years can consent on their own behalf if they have an understanding of the proposed treatment and its associated risks.
- The doctor/dentist should be the judge of whether the child does understand (termed 'Gillick competent').

The law does not stipulate a specific age at which a child may be considered 'Gillick competent'.

Section 6 asked for any comments regarding consent.

The results were anonymous, but a code was included to enable non-responders to be sent a second copy.

We received 48 replies, and after a second questionnaire was sent to the non-responders, the total was 58. Non-responder bias was reduced by attempting to maximize the response rate. A covering letter was enclosed to explain the survey, and a stamped addressed envelope was provided for ease of reply. A reminder was sent to the non-responders. The data were collected and entered onto Microsoft Excel (Microsoft Corporation, Redmond WA, USA).

Results

Eighty-four questionnaires were sent out, and 58 (69%) responses were received. Of these, eight were discounted because they were incorrectly completed. A further two were discounted because the respondents had retired or moved from the North-West. This left 48 valid respondents. This number was lower than was hoped for, but the questionnaire was sent out at an extremely busy time for practitioners, with the introduction of the new dental contract and its necessary negotiations. This may have introduced some non-responder bias.

Section 1: Main type of practice worked in by respondents

Of the 48 respondents, 27 (56%) worked mainly in specialist practice and 21 (44%) in hospital services. All the respondents undertook primarily NHS work.

Forty-five (94%) routinely obtained consent from patients pre-treatment, and three (6%) did not.

Of these three, two were from specialist practice and one from the hospital service. The only difference in the results between the hospital service and general practice was that the hospital service was more likely to give a copy of the consent form to the patient/parent (81%) than were specialist practitioners (27%).

Section 2: Subjects that the respondents routinely warned about

Practitioners were asked which subjects they routinely discussed when obtaining consent, and how this was done.

- Verbally: the subject is only discussed verbally and no written record is made.
- Written: the subject is discussed and then recorded in the patient's notes.
- Form: a separate consent form is used to cover this subject.
- Never: patients are never warned about this subject.

The results are shown in Figure 2.

The main features of note were those subjects that were never discussed.

Root resorption was never discussed by 53%, and 9% never discussed this even when there were increased risk factors. Sixteen per cent of practitioners did discuss this with the patient where there was a predisposition to resorption, but did not record it in the notes or as part of a separate consent form.

The risk of devitalization of a traumatized or heavily restored tooth was not discussed by 16% of respondents. Thirty-three per cent also did not discuss the fracture risk to crowns or large restorations.

Many of the subjects were discussed verbally with the patient but no written record was made in the patient's notes.

The process of consent should additionally involve a discussion of the benefits of treatment. Sixteen practitioners (36%) did not mention the advantages of having orthodontic treatment.

On returning their questionnaire, practitioners mentioned that headgear and existing periodontal disease in adult patients would also be important subjects for discussion.

Section 3: Use of a consent form (Table 1)

Of the 45 practitioners who did obtain consent from their patients, 27 (60%) used a form. This section asked about its design and how it was used. Sixteen (59%)

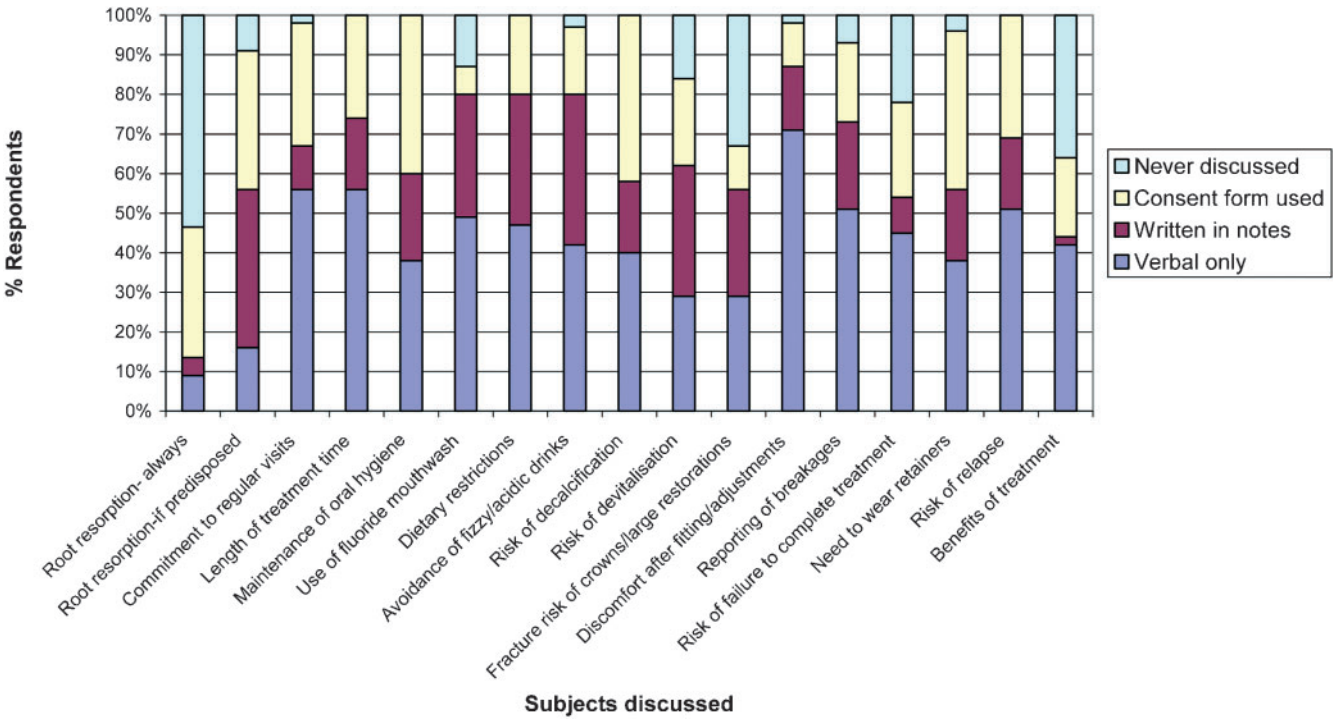

Figure 2 Subjects routinely discussed and method used (*x*-axis: subjects discussed; *y*-axis: percentage of respondents)

forms were based on a recommended design from an organization such as the British Orthodontic Society. Twenty-three (85%) practitioners gave the form to the patient/parent to read themselves.

Twenty-four (89%) had the form signed by the patient/parent. Eighteen (67%) countersigned the form, and 17 (63%) gave a copy to the patient/parent. As noted earlier, this was the only major difference between hospital and specialist practice, with the hospital practitioners being more likely to give a copy to the patient/parent (81% as opposed to 27% of specialist practitioners).

Nine examples of consent forms were returned. Of the five from the hospital service, four were general consent forms, which could be used for any medical procedure, with just one being a dedicated orthodontic consent form. Of the four examples returned from specialist practice, all were dedicated orthodontic consent forms.

One consent form gave the patient an opportunity to raise any concerns, and made a note of any information sheets given to the patient. The job title of the person obtaining consent was also noted.

Some consent forms contained general points, such as mentioning that appointments could be in school time.

Section 4: Delegation

Of the 45 respondents who did routinely obtain consent from their patients, 40 (89%) went over consent themselves, and seven (16%) assigned this task to a member of staff. In two cases, both the practitioner and a member of staff went over consent with the patient.

Table 1 Use of the consent form.

	Yes	No
Is consent form based on a recommended design?	16 (59%)	11 (41%)
Do you give it to patient/parent to read?	23 (85%)	4 (15%)
Do you get the consent form signed by patient/parent?	24 (89%)	3 (11%)
Is the consent form countersigned by you or an assigned member of staff?	18 (67%)	9 (33%)
Do you give a photocopy to patient/parent?	17 (63%)	10 (37%)

Section 5: Age of consent (Table 2)

Twenty-eight (62%) respondents would allow a patient under the age of 16 years to consent to treatment if they considered that the patient was Gillick competent.[19] The range of ages can be seen in Table 2. The lowest suggested age was 10 years, and six (21%) practitioners would accept any age.

Section 5: Comments section

Some of the comments received relating to consent were as follows:

'Essential!'

'I would be very interested to see a model/ideal/standard orthodontic consent form used by most practitioners. It would help ensure consistency across all practices.'

'Gillick competency is not a good basis for deciding treatment, it is more dependent on maturity of the patient.'

One comment dealt with the issue of children living away from home. The practitioner worked in an area where children were treated who attended from a boarding/residential school. When the parent could not attend, they wrote a detailed letter accompanying the consent form, a copy of which they requested to be returned.

Discussion

This survey showed that most practitioners who responded do obtain consent from their patients prior to orthodontic treatment. There was, however, some variation in the subjects covered.

Of the three practitioners who did not obtain consent, one was in hospital service and the other two worked in specialist practice. We might assume that there was non-verbal, implied consent by the patient sitting in the chair while treatment was performed. However, this would not be considered as valid consent.

Table 2 Ages that would be considered for accepting consent from a Gillick-competent patient.[19]

What is the youngest age you would consider?	Number of practitioners
Any age	6 (21%)
10	1 (4%)
12	3 (11%)
13	1 (4%)
14	16 (56%)
15	1 (4%)

The age of consent accepted by practitioners showed some variation. Notably, six practitioners (21%) would accept any age. There may be a lower limit beyond which most practitioners would not consider it reasonable to accept consent.

There are some weaknesses associated with this survey. For example, although all practitioners in the North-West were sent a copy of the questionnaire, which achieved a response rate of 69%, this fell to 57% after discounting practitioners who had moved or retired and those who had incorrectly completed the form. This low rate may be due to the heavy workload involved by the contract changes being implemented at the time. However, it may be useful to regard this as an initial study, which could be followed up in the future by a national survey. In addition, there may also be an element of non-responder bias. Practitioners who did respond may be those who are more likely to obtain consent, and therefore the actual number obtaining consent may be lower than the results of this survey shows. Also, since practitioners were prompted about the areas that might be discussed at consent, this may have resulted in more positive answers than were actually justified ('social desirability').

In 2002, a survey (not dissimilar to the current survey) was undertaken of consent practices of consultant orthodontists in the UK. The response rate achieved was almost 90% (199 returned out of 222 sent), and it is disappointing that the response rate was considerably lower in this survey. However, while 41% of consultants obtained written consent in 2002, the figure was higher in our survey of specialist orthodontic practitioners, of whom 60% used a consent form. Nevertheless, as indicated, the low response rate may have negative implications.

There are also some strengths associated with this survey. For example, it has highlighted the areas where some changes in practice may be beneficial. In the UK, consent is a process that helps protect clinicians and patients. The results of this survey show that not all practitioners are obtaining consent, and those who do are missing some important areas for discussion. Also, in these days of increased litigation, it is easy to concentrate on the risks of treatment and forget about the beneficial aspects of orthodontic work. If the process of consent is thoroughly completed pre-treatment, there will be, first, a better understanding between clinician and patient, as the latter will have received a full explanation.[21,22] Secondly, if there should be a dispute, then both the treatment and the consent process will be easier to defend. This is an area of clinical practice that can protect the clinician from complaints, civil claims and criminal charges.[21]

The GDC, the UK's regulatory body, states that dental professionals must make themselves aware of laws and regulations that affect their work.[9]

As the current changes in the NHS are introduced, it may be that consent will be an area that Primary Care Trusts will focus on when inspecting the practices now contracted to provide orthodontic services. The Department of Health publication, *Personal Dental Services—a Step-by-Step Guide*, supports high-quality practice and states that the new system will be underpinned by locally determined clinical governance arrangements, with practices expected to use their clinical and professional expertise to provide a high-quality service for patients.[23] This will have implications for clinical practice. Practice inspections and appraisal systems that are currently being introduced may also address this issue. We need to make ourselves aware of the current regulations and implement systems to ensure that valid consent is obtained.

Useful further work in this area would be to conduct a national survey of consent practices of specialist orthodontic practitioners. Improvements to our North-West survey could be made, including collecting data on the gender, age and number of years in practice. The response rate could also be improved with more follow-up, and an improvement in design may reduce the number of forms that are incorrectly filled in. A national survey would also be interesting, as all our practices were mainly NHS practitioners, and a national survey would show any differences between NHS and private practice. There could be the inclusion of additional subjects, such as headgear and periodontal disease.

Recommendations

- It is essential to obtain valid consent before embarking on treatment. The use of a consent form would demonstrate that a consent process had been completed in the event of any dispute between practitioner and patient. Consent should not be considered a one-off event, so if the treatment plan changes, then consent must be re-established for any modifications.
- Our recommendation would be to introduce a policy on consent by referring to the GDC booklets and obtaining current information from the defence unions. The British Orthodontic Society is an excellent source of information, and a consent form can be based on their model.
- Do not forget to mention the benefits as well as the risks of treatment.
- Where there are known risk factors, such as unfavourable root morphology, these should be discussed.
- The patient/parent ought to be given a copy of the consent form, which should be signed by all parties.
- Any team members to whom obtaining consent is delegated must be given appropriate training, and a record must be made of such training.

Conclusions

- The majority of specialist practitioners in the North-West of England who responded to this survey are obtaining consent prior to treatment.
- Forty per cent of specialist practitioners who responded do not use a form.
- The subjects discussed with patients as part of the consent process varied.
- Aspects of consent practice that may benefit from improvement have been highlighted.

Contributors

Christine Taylor was responsible for the original concept and literature review. Christine Taylor and Danielle Chappell were both responsible for the questionnaire design, data analysis, writing the article, critical revision and final approval of the article. Danielle Chappell was responsible for the questionnaire distribution, follow-up and data collection. Christine Taylor is the guarantor.

Acknowledgement

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Appendix 1

Please circle your answers ID No _____

Section 1

1A Are you in..... Specialist practice(>75%)? Hospital service(>75%)? Mixed?
Please indicate your main occupation.

1B Is your work ..... mainly NHS? (>75%) mainly Private? (>75%)

1C Do you routinely consent your patients pre-treatment? Y N

If yes to question 1C, please go to Section 2.
If no, please go to Section 6

Section 2 Please indicate which subjects you routinely warn/advise about and how, by circling V, W, F or N to indicate that you:-

V- only talk to the patient verbally about these topics and make no written record
W- it is recorded in the written patient notes
F- it is part of a separate consent form
N-you never warn about this topic

	Please circle one answer only				
2A-Root resorption – i) Always?	V	W	F	N	
-ii) Only if there was a root shape which predisposed to resorption?	V	W	F	N	
2B-Commitment to regular visits?	V	W	F	N	
2C-Length of time of treatment?	V	W	F	N	
2D-Maintenance of good oral hygiene?	V	W	F	N	
2E-Use of Fluoride mouthwash?	V	W	F	N	
2F-Dietary restrictions?	V	W	F	N	
2G-Avoidance of fizzy/acidic drinks?	V	W	F	N	
2H-Risk of decalcification?	V	W	F	N	
2I-Risk of devitalisation to traumatised/heavily restored teeth?	V	W	F	N	
2J-Fracture risk to any crowns/large restorations?	V	W	F	N	
2K-Discomfort after fitting/adjustments?	V	W	F	N	
2L-Reporting of any breakages?	V	W	F	N	
2M-Risk of failure to complete treatment?	V	W	F	N	
2N-Need to wear retainers post-treatment?	V	W	F	N	**PTO**

2O-Risk of relapse? V W F N

2P-Do you give details of any other risks/side-effects, if so, what?

_____

2Q-Benefits of treatment? V W F N

If you use a consent form please complete section3
If not, please go to section 4.

Section 3

	Yes	*No*
3A Is the consent form based on a recommended design from an organisation such as the British Orthodontic Society?	Y	N
3B Do you give it the patient/parent to read themselves?	Y	N
3B Do you get the consent form signed by the patient/parent?	Y	N
3C Is the consent form countersigned by you or an assigned member of staff?	Y	N
3D Do you give a photocopy of the consent form to the patient/parent?	Y	N

Please enclose an example of your form, Thank you
Now go to section 4.

Section 4

4A Do you personally go over consent with the patient/parent? Y N

4B Do you assign this task to a member of staff? Y N

Now complete section 5,

Section 5

5A Would you accept consent from a patient under 16 years if you considered that they were Gillick competent? Y N

5B What would be the youngest age that you would consider? _____years

Please complete section 6

Section 6

Please add any comments you wish to make regarding consent.

_____
_____
_____
_____

Thank you for completing our questionnaire. Please return in SAE enclosed. CT / DC