It is a fundamental principle of good dental practice that patient consent or proper authority is obtained before any treatment starts or information about a patient is disclosed.

Consent is important because any investigation or treatment, or even deliberate touching, carried out without a patient’s consent or proper authority may be regarded as battery and could result in:
• an action for damages
• a finding of impaired fitness to practise by the GDC
• criminal proceedings.

Adults with capacity
Consent is the expressed or implied permission of a patient to undergo a dental examination, investigation or treatment. It is essential that consent is given freely and with adequate information and understanding of:
• the condition to be treated
• the procedure or treatment, why it’s necessary and the risks and benefits
• other appropriate options for treatment, and their risks and benefits
• the health implications of giving and withholding consent.

Children and adults without capacity
In the case of children and adults without capacity, seeking authority for their treatment has additional considerations.
It is exceptional for an adult to be considered unable to consent to dental treatment. The tests for capacity and the ability of a patient to make decisions is set out in the Mental Capacity Act 2005 (MCA), and are supported by the Code of Practice established under the Act, which dental professionals are expected to follow.

**Key points**

1. Competent adults can consent to dental treatment. A competent adult is a person aged 18 or over who has the capacity to make their own decisions about treatment.

2. A person lacks capacity when they are unable to make a decision in relation to a given matter because of an impairment of or a disturbance in the functioning of the mind or brain.

3. To be able to make a decision a patient should be able to:
   - understand the information relevant to the decision
   - retain that information
   - use or weigh up that information as part of the process of making the decision
   - communicate the decision by any means.

4. If a patient has a mental disorder or learning difficulties, you should not assume they cannot give consent. They may fulfil all the capacity criteria necessary to make a decision about treatment. (See section 3.6 Assessing mental capacity).

**Our advice**

Ensure your patient understands the information you have provided to them. Check that they are able to make a decision based on that information and document that they have understood the information you have given.

**Checklist**

- Have you assessed the patient to find out if they have the capacity to consent to treatment?
- Can the patient retain the information long enough to be able to make a decision?
- Have you recorded in the patient’s notes the discussions you have had with them about the treatment options and their risks and benefits?
- Have you checked and documented that the patient understands the information given?
Certain criteria must be fulfilled for consent from a patient with capacity to be considered satisfactory.

**Key points**

1. Consent must be sought **before** any investigation or treatment.

2. The way consent is obtained must be tailored to suit the patient’s needs. For example, encourage patients with communication difficulties to have a friend, relative or carer with them to help.

3. Paragraph 3.1.3 of Standards for the Dental Team (2013) describes the information that patients might want to know before they consent, including:
   - options for treatment, and their risks and benefits, and why you think a particular treatment is necessary and appropriate for them
   - the consequences, risks and benefits of the treatment you propose (See section 3.3 Risk and the Bolam test)
   - the prognosis and what might happen if the treatment is not given
   - whether the treatment is guaranteed, how long for and any exclusions that apply.

Failure to give correct or sufficient information when obtaining consent may breach your duty of care. A patient may be entitled to compensation if it is proved there was a negligent failure to inform and, as a direct result, they suffered harm. The patient must be given a reasonable amount of time to consider the information to make a decision.

4. The **cost of any examination, investigation or treatment** should also be explained before it starts, including whether treatment is being carried out on the NHS, privately or on some other payment basis. Note that a patient who agrees to pay the bill has not necessarily consented to treatment.

5. If a **patient’s condition alters** significantly between initial consultation and treatment, causing a change in the nature, purpose or risks of the procedure, you must explain the changes and obtain consent again. A change in the cost of treatment should be reviewed with the patient.

6. **Duress** of any form, including the undue influence of relatives or others, may invalidate consent.

**Our advice**

It can be a good idea to obtain consent at an earlier date than that of treatment, allowing a ‘cooling off’ period in which a patient can think over their decision and/or take advice.

It is best to re-confirm consent with a patient immediately before treatment.

**Checklist**

- Have you explained all the relevant facts to the patient and established that they understand them?
- Have you given the patient time to consider all relevant information before making a decision?
- Are you confident the patient is not under any coercion or pressure to give (or withhold) consent?
- Have you retained all written consent documents with the patient’s records, and made a contemporaneous note in the record of the discussions with the patient?
The treatment proposed to a patient may carry risks. For consent to be valid, the patient must be warned of those risks and understand their implications.

Key points

1. In considering what, and how much, to tell a patient about the treatment or process, and the likelihood and seriousness of potential risks, you should consider the patient's:
   • ability to understand
   • physical and emotional state
   • possible questions and your responses
   • stated wish to have information.

2. Patients should be given information that would, in the circumstances, be considered reasonable by a responsible body of dental opinion. (See The Bolam test below).

The Bolam test

The courts apply the Bolam test in cases of alleged clinical negligence where it is maintained that no, or insufficient, warning was given that a particular treatment carried known risks.

Mr Bolam suffered fractures as a result of electro-convulsive therapy (ECT), during which he was neither restrained nor given muscle relaxants. He alleged negligence on the grounds that he had not been warned of the risks of ECT and so had no chance to refuse treatment. Expert evidence maintained that a ‘responsible body of practitioners’ would not have warned of the risks. The Bolam test states that a doctor who ‘acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view’.

However, in the case of Sidaway, the House of Lords modified the Bolam test, adding that the courts also have the right to find that a responsible body of medical opinion may be unreasonable in failing to warn, and therefore negligent.

The cases have two main implications for dental professionals in England and Wales:

• a case of alleged negligence would not ordinarily be proved in court if it was established that a responsible body of reasonable professional opinion would not have mentioned the risks.
• it is necessary to answer patients’ questions truthfully and fully.

Our advice

Ensure that the patient is provided with enough information about the risks and benefits of all treatment options before treatment starts.

Patients have a right to information and their questions should be answered truthfully and fully.

Confirm with the patient that they still understand the risks and benefits at every appointment during the course of treatment.

Checklist

• Have you given the patient an opportunity to ask questions, and have you answered them all fully?
• Have you provided the patient with adequate information about the risks of each treatment procedure, and of not proceeding with treatment?
• Have you recorded all conversations about the risks and benefits of treatment options in the patient’s notes?

References

1 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
2 Sidaway v Board of Governors of Bethlem Royal and the Maudsley Hospital [1985] 2 WLR 480
It is a general, legal and ethical principle that all members of the dental team providing treatment should obtain consent before starting treatment. Where this is not practicable, another appropriately qualified dental professional who is familiar with the proposed treatment should obtain consent. You should make sure the other professional understands the risks and follows the GDC’s guidance on consent.

Key points
1. All members of the dental team have a responsibility to verify that consent has been properly obtained before starting treatment.
2. Consent to dental examinations is implied when, having been told what is planned and properly advised, the patient voluntarily sits in the dental chair and opens their mouth.
3. For procedures other than dental examinations, including radiographs, the patient’s express consent, oral or written, is required.
4. For treatment under sedation (intravenous or inhalation), a patient’s written consent is required. The GDC states in its guidance Standards for the Dental Team (2013) paragraph 3.1.6 that written consent must be obtained where treatment involves general anaesthetic or conscious sedation.
5. A patient’s signature on a treatment plan or consent form is of secondary significance to the quality of explanation and information given to (and understood by) the patient. However, a signature on a treatment plan or consent form is evidence that consent has been obtained. In general, the required entries in the clinical records, detailing the discussions with and warnings given to the patient are equally important.
6. A consent form should not be altered after a patient has signed it.
7. During treatment, you should only carry out procedures to which a patient has expressly consented. The only exception is emergency treatment necessary to prevent serious harm or to safeguard a patient’s life.

Our advice
When a patient has given oral consent to treatment, you should enter in the patient’s clinical records the advice given, including any warnings, and the fact that the patient has understood and consented. This is particularly important where treatment is significant and not routine.

Although a consent form may not always be necessary, you may wish to consider using one as it can help serve as documentary evidence should a dispute over consent arise later.

Checklist
• Have you made a contemporaneous note in the records of the discussions with the patient relating to the consent process and retained all written consent documentation with the patient’s records?
• If you have made changes to a planned procedure, have you fully discussed the changes with the patient and, if necessary, had a new consent form signed?

Reference
When consent is withheld

**Patients may give consent. They may also refuse or restrict it.**

**Key points**

1. Competent adults have an absolute right to withhold their consent to treatment for any reason – or for no reason at all. This is the case even if their refusal appears unreasonable and not in their own best interests.

2. When obtaining consent, dental professionals should take into account the patient’s religious, cultural and other beliefs. These may lead them to refuse treatment, or specific aspects of treatment e.g. a blood transfusion.

3. The difficulties caused by restricted consent do not alter your legal and ethical responsibilities towards the patient, or their right to receive reasonable and proper care.

4. Refusing one aspect of treatment does not give the patient the right to alternative treatment not normally available to other patients.

5. When a patient refuses to consent to an element of the treatment plan and this threatens the outcome of other elements, you must explain the consequences of their decision. The original treatment plan may have to be revised or abandoned if the patient’s wishes mean it is no longer appropriate and in the patient’s best interest.

6. Consent may be withdrawn at any time, even during treatment. A request to stop treatment should be complied with immediately, unless the patient’s capacity to make a decision is impaired at that moment to the extent that they are no longer competent to consent to treatment. You should still take the request into account in assessing the patient’s best interest. You should weigh up whether it is in the patient’s best interest to stop treatment, including whether the harm caused by stopping treatment outweighs the risk of continuing. If stopping treatment would be dangerous to the patient and they are unable to appreciate this, it may be possible to continue under the protection of the Mental Capacity Act 2005 and/or common law.

**Our advice**

The model consent form issued by the Department of Health allows patients to specify which procedures they do not wish to be carried out. You might want to consider using it routinely in your practice.

**Checklist**

- Are you confident you know which aspects of treatment the patient has agreed to and which they have not?
- Have you confirmed at each appointment that the patient is happy to proceed with treatment?

**Reference**

**Assessing mental capacity**

*Adults with capacity aged 18 and over are competent to make decisions about their own treatment.*

For people aged 16 and over who lack capacity, the **Mental Capacity Act 2005** (MCA) provides a legal framework (England and Wales only). Among other things, the Act establishes several overarching principles, including that an act done on behalf of an adult who lacks capacity must be done in their best interests. The Act is supplemented by a detailed Code of Practice, with which dental professionals are expected to comply.

In Scotland, the relevant legislation is the **Adults with Incapacity (Scotland) Act 2000**.

The following points relate to the position in England and Wales.

**Key points**

1. The fact that a person has a mental disorder or learning difficulties is not, on its own, grounds for deciding that person does not have capacity.
2. Capacity is assumed unless it is established otherwise. You should not assume, by making judgments from a patient’s behaviour or appearance, that the patient lacks capacity.
3. You should take all steps practicable to help patients make decisions about their treatment before concluding that they lack capacity.
4. If a patient appears to make an unwise or irrational decision, this is not sufficient reason to treat a patient as lacking capacity.
5. In relation to assessment of the ability to make a decision, the MCA says the patient must be able to:
   - understand the information relevant to the decision. This includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make a decision
   - retain that information
   - use or weigh up that information as part of the process of making the decision
   - communicate their decision. This may be by talking, using sign language or other means of communication.
6. A patient’s capacity may vary depending on the complexity of the decision to be made and may fluctuate with time.
7. If an adult patient lacks capacity, and you are faced with providing treatment without consent, you should take into account the views of relatives and/or carers and/or anyone named by the patient and the patient’s present and previously expressed wishes in helping to determine if the treatment is in the patient’s best interests (see in section 3.7 Best interests).

**Our advice**

You should assume that all adult patients have the capacity to consent to treatment unless you determine they lack that capacity. If you decide an adult lacks the capacity to consent, you should then decide if it is in the patient’s best interests to proceed with treatment.

When assessing whether treatment is in the patient’s best interests, you should consider whether the patient might regain capacity later. If a patient has fluctuating capacity, it would be very unusual for dental treatment to be appropriate while the patient lacks capacity, when it could be left until the patient regains capacity and can consent.

**Checklist**

- Have you made sure that the patient has all the information they need to make a decision about treatment?
- Is the information presented in a way that is easier for the patient to understand e.g. by using simple language or visual aids?
- Have you recorded in the clinical notes the processes you went through in determining capacity?
- If the patient lacks capacity, have you recorded in the notes the basis on which a decision to treat, or not treat, was in the patient’s best interests and the steps taken to establish that?
Dental professionals need to be aware of a number of factors before making decisions on behalf of adults lacking capacity.

Key points

1. Any treatment or decision must be made in the patient’s best interests. (See overleaf: Best interests).
2. Before a treatment starts, or a decision is made, you should consider whether the purpose of the decision or treatment can be achieved just as effectively in a way which is less restrictive of the patient’s rights and freedom of action.
3. A patient who now lacks capacity may have made an advance decision at a time when they had capacity, to refuse or limit treatment. If you are aware of such a decision and you can establish that it is valid and applies to the treatment proposed, you must follow it.
4. In England and Wales, patients can appoint an attorney under a Lasting Power of Attorney (LPA) who may authorise dental decisions on their behalf.
5. LPAs cannot give attorneys the power to demand specific forms of dental treatment if dental professionals do not believe they are necessary or appropriate to the patient’s condition.

The MCA Code of Practice\(^1\) provides helpful guidance and examples regarding the assessment of a patient’s best interests. It makes clear that the concept of best interests extends beyond purely clinical issues. You need to take into account relevant factors such as the patient’s values and preferences when competent, their psychological health, well being, quality of life, relationships with family or other carers, spiritual and religious welfare and their financial interests.

6. Where the patient has no one close to represent them, you may need to seek the views of an Independent Mental Capacity Advocate (IMCA) in deciding the patient’s best interests in certain circumstances where ‘serious medical treatment’ is proposed. These circumstances include situations where there is a fine balance between the likely benefits and burdens/risks of treatment.

7. In Scotland, under the Adults with Incapacity (Scotland) Act 2000, a competent adult can nominate a welfare attorney or proxy to make medical decisions on their behalf should they lose the capacity to make those decisions for themselves.

8. In Scotland, the law also provides for a general power to treat a patient who is unable to give consent. The dental professional primarily responsible for treatment must have completed a certificate of incapacity before any treatment is undertaken, other than in an emergency.

Our advice

Decide what constitutes a patient’s best interests by taking into account factors other than just their dental condition. Consider consulting with others, including getting a second opinion from a colleague, before proceeding with treatment.

Checklist

- Have you recorded in the clinical notes the process by which you worked out the patient’s capacity or lack of it, and their best interests? Have you set out how the decisions were reached, the reasons, who was consulted and the factors taken into account?
- Have you considered alternative treatments which may be more appropriate for the patient? The treatment you provide should be that which is the least restrictive of the patient’s rights and freedoms.

Reference

\(^1\) Mental Capacity Act 2005, Code of Practice, Chapter 5
Best interests

A key principle of the Mental Capacity Act 2005 (MCA) is that all steps and decisions taken for someone without capacity must be taken in the person’s best interests. In determining this, you should consider all the relevant circumstances, including:

- the patient’s past and present wishes and feelings, in particular any relevant written statement made when the patient had capacity
- the beliefs and values likely to influence a decision if the patient had capacity
- other factors they would be likely to consider if they were able to do so.

If possible, take into account the views of those named by the patient as someone to be consulted as to their best interests. If no one has been named, these matters ought to be considered with a patient’s close relative and/or friend or their carer.

Section 4 of the MCA deals specifically with the best interests of a patient.

You should not determine a patient’s best interests on the basis of their age, appearance, condition or behaviour.

Dental professionals involved in the care of someone who lacks capacity are advised1 to keep a record in the clinical notes of how they established the patient’s best interests.

Reference

1 Reference Guide to Consent for Examination or Treatment, DoH, 2009
**Patients without capacity to consent are entitled to proper dental treatment.**

**Key points**

1. Where a patient lacks capacity to give or express consent, either temporarily or permanently, then treatment necessary to preserve the life, health or well being of the patient may be given where it would be lawful under the terms of the Mental Capacity Act 2005 (MCA).

2. As a dental professional you must provide a standard of care that would be consistent with that of a responsible body of your professional peers. This is the Bolam standard (see section 3.3 Risk and the Bolam test). You are expected to act in accordance with a responsible body of relevant and reasonable professional opinion.

3. The proper care of patients with mental incapacity includes operations and substantial overall treatment, and also routine dental treatment.

4. The MCA Code of Practice guidance means you should involve others e.g. relatives, carers and specialists, in the decision-making process to determine the best interests of a patient who lacks capacity.

5. It is unlikely in dental treatment that you will have to apply to the court to determine the capacity or best interests of a patient. However, it may be appropriate to do so where there is dispute with or between, relatives or those caring for the patient. You may find it helpful in such circumstances to get a second opinion from another appropriate professional.

**Our advice**

Ensure you provide all appropriate treatment for patients who lack the capacity to consent. Remember that this treatment must be in the individual patient’s best interests.

**Checklist**

- Have you formulated an appropriate treatment plan?
- Have you consulted with others before finalising your treatment plan?
- Would your treatment plan be regarded as appropriate by a responsible body of opinion i.e. does it meet the Bolam standard?

**Reference**

1 Bolam v Friern Hospital Management Committee [1957] 1 WLR 582
The age at which children are deemed capable of giving consent for dental treatment in England and Wales\(^1\), Scotland\(^2\), and Northern Ireland\(^3\) is 16.

**Key points**

1. In England and Wales, while children remain minors until they are 18, once a child reaches the age of 16, they are deemed to be capable of consenting to treatment as if an adult.

2. In all cases, treatment should only be given if it is in a child’s **best interests**.

3. Valid consent of a child over 16 cannot be **overridden** by a refusal from those with parental responsibility. However, in some cases a refusal of consent by a child over 16 can be overridden by a child’s parents or guardians or by the court. (See section 3.10 Consent and children under 16).

**Our advice**

Although there is no legal requirement to do so, if a 16 or 17-year old needs to undergo major or hazardous elective surgery, you may wish to discuss the treatment with the parents, subject to the patient’s permission.

**Checklist**

If a child is aged 16 or 17 have you:

- obtained informed consent from the patient?
- asked for permission to discuss their treatment with a parent or someone with parental responsibility if you believe such a discussion is appropriate?
- recorded their permission and your discussions in your notes?

**References**

1. Family Law Reform Act 1969, section 8
2. Age of Legal Capacity (Scotland) Act 1991
3. Age of Majority Act (Northern Ireland) 1969, section 4(1)
Children under 16 can give valid consent to treatment if they are competent. This was confirmed by the House of Lords in the 1985 Gillick judgment.

Key points

1. The ability to give valid consent will depend on a child’s maturity and ability to understand what the treatment involves. To be Gillick-competent, a child must:
   • understand the nature of the proposed treatment, its consequences and the alternatives, including no treatment
   • retain that information
   • use or weigh up that information in making a decision
   • communicate that decision.

2. If a child is not Gillick-competent, authority to treat may be given by someone with parental responsibility under the Children Act 1989. (See overleaf: Parental responsibility).

3. You should not delay emergency treatment required to save life or prevent serious harm if you are unable to get authority from an adult with parental responsibility.

4. In deciding whether to treat, your overriding consideration must always be what is in the best interests of the child.

5. If one person with parental responsibility authorises treatment, it is not usually necessary to obtain the authority of another person with such responsibility. In non-urgent cases, where there is a dispute, it would be wise to seek a resolution that is in the child’s best interests. If the parents are separated or divorced, and the child is not yet competent to authorise disclosure, information may be disclosed to either parent if it is in the child’s best interests, unless the court has removed parental responsibility from the parent.

Our advice

Even in the case of Gillick-competent children, you may wish to encourage children to discuss decisions concerning their health with their parents or carers.

Checklist

- If your patient is under 16 years of age, have you considered whether they are Gillick-competent?
- If you assess the child as competent, have you asked the patient’s permission to discuss their treatment with a parent?
- Do you know who has parental responsibility?
- If you assess the child is not Gillick-competent, have you obtained authority to treat the patient from someone who has parental responsibility?

Reference

1 Gillick v West Norfolk and Wisbech AHA (1985) 3 All ER 402-437
Parental responsibility*

Births registered in England and Wales

A child’s natural parents both have parental responsibility if they were married at the time of the birth or marry later.

A father who is named on the birth certificate will usually have parental responsibility if the child was born on or after 1 December 2003.

If a child was born prior to December 2003, and the parents were unmarried, then only the mother has automatic parental responsibility. However, under Section 4 of the Children Act 1989, if the child’s father is not married to the mother he may acquire parental responsibility if he becomes registered as the child’s father, or makes an agreement with the mother (including by marriage), or by a court order.

Section 4A of the Act, provides for step-parents to acquire parental responsibility in certain circumstances.

Births registered in Scotland

A father has parental responsibility if he is married to the mother when the child is conceived, or marries her at any point afterwards. An unmarried father has parental responsibility if he is named on the child’s birth certificate (if the child was born on or after 4 May 2006).

Births registered in Northern Ireland

A father has parental responsibility if he is married to the mother at the time of the child’s birth. If a father marries the mother after the child’s birth, he has parental responsibility if he lives in Northern Ireland at the time of the marriage.

An unmarried father has parental responsibility if he is named, or becomes named, on the child’s birth certificate (if the child was born on or after 15 April 2002).

Same-sex parents

- **Civil partners**: same-sex parents who were civil partners at the time of the treatment will both have parental responsibility.
- **Non-civil partners**: for same-sex parents who aren’t civil partners, the second parent can either:
  - apply for parental responsibility if a parental agreement was made
  - become a civil partner of the other parent and make a parental responsibility agreement or jointly register the birth.

Reference
*www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility*
Occasionally, a Gillick-competent child or an adult with parental authority may refuse to consent to or authorise treatment.

Key points

1. Children aged 16 and 17, or a Gillick-competent child, do not have an absolute right to refuse treatment. Their refusal will not override authorisation by someone who has parental responsibility for the child, or the court. (See section 3.10 Consent and children under 16).

   In deciding whether or not to treat a child in such circumstances, your assessment of whether it is in the child's best interests to treat against their wishes should include:
   - the age and emotional development of the child
   - the nature and consequences to the child of the proposed treatment
   - the effect on the child of imposing treatment against their wishes
   - the nature of the condition and the consequences to the child if untreated.

2. It may be unlawful for a dental professional to treat a child who is not considered Gillick-competent against the wishes of a parent or guardian.

3. If failure to treat immediately would result in death or permanent injury, you may conclude that treatment is justified and in the child's best interests, in spite of a refusal to consent. You should consider the possibility of obtaining a court order.

4. An application can be made for a specific issue order to carry out treatment without parental authority under Section 8(1) of the Children Act 1989. Generally, a court asked to override parental authority will proceed cautiously. If you find yourself in this situation, call us.

Our advice

Where parents' wishes conflict with reasonable clinical practice and are not in the best interests of a child, you ought not to proceed with treatment. A second opinion is strongly advised, and you may need to make an application to the court.

You should consider all significant factors when assessing a child's best interests, including the appropriateness and availability of alternative measures.

Checklist

- If a child under 16 presents for examination without an adult, or with an adult who does not have parental responsibility, is the child Gillick-competent and should you seek the parent or guardian's authority to proceed?
- Have you kept a record of the assessment and the decision in the patient's clinical notes?
The Children Act 1989 makes a clear distinction between children who are the subject of a care order and those who are being looked after on a voluntary basis.

Key points

1. When a child is the subject of a care order, the local authority has parental responsibility and can authorise treatment on the child’s behalf. However, the order does not deprive the child’s parents of responsibility or ability to authorise treatment.

2. Where the local authority and parents both have parental responsibility, the local authority can decide the extent to which a parent or guardian may exercise their responsibility. The local authority’s responsibility may override that of the parents, where this is necessary for the child’s welfare.

3. When major procedures are being considered for a child who is the subject of a care order, the local authority is likely to involve the parents in the decision.

4. The local authority does not have parental responsibility over children who are being looked after on a voluntary basis. You should seek consent from the child under 16, if Gillick-competent, or authority from someone with parental responsibility for the child, before starting non-emergency work.

Our advice

When considering major treatment on a child who is the subject of a care order, it may be wise to seek the authority of others with parental responsibility, as well as the local authority. In any event, you should seek the child’s consent when they are capable of giving it.

Checklist

- If examining or treating a child in care, do you know who has parental responsibility?
I provided an emergency consultation to a new patient complaining of severe pain in the upper right quadrant of her mouth.

After examination I found the UR8 acutely tender to percussion. The other teeth looked sound. I took bitewing and periapical radiographs which revealed a large carious lesion in UR8. I diagnosed acute apical periodontitis and offered the patient the option of a root filling and restoration. The patient requested extraction, which I carried out under local anaesthetic.

The following Saturday afternoon, the patient requested another emergency consultation. I agreed to see her privately without charge.

In the surgery the patient complained of localised pain in the right side of her mouth that responded to hot and cold. I examined her and found that none of the upper or lower teeth was tender to percussion but the UR6 responded positively to an ice stick, with lingering pain. A fracture line was clinically visible in this tooth and the evidence of a pulpitis suggested that this communicated with the pulp. As before, I gave a choice of root canal filling and restoration at a future time, but the patient chose to have an extraction. A year later, solicitors acting for the patient began pursuing a claim for compensation. They alleged that I failed to properly assess the cause of pain on the second visit and the UR6 was extracted inappropriately. They also alleged I failed to obtain valid consent to this extraction as no alternative treatment options were discussed.

The solicitors asserted that the most likely cause of the patient’s pain at the second visit was post-operative inflammation following the UR8 extraction. They said that application of an ice stick did not support a diagnosis of irreversible pulpitis and the radiographic evidence did not suggest a fracture line.

The patient contended that if she had been aware that root canal treatment was an option, she would have chosen this to avoid losing another tooth.

How we helped

We sought expert clinical advice. This confirmed that hypersensitivity to cold remaining after the stimulus was withdrawn was a classic presentation of irreversible pulpitis that would require either root canal treatment or extraction of the tooth. It was unlikely to be associated with a nearby extraction socket.

Our expert noted that the member had recorded within his contemporaneous notes his observation of a fracture and that this was consistent with a moderate occlusal amalgam restoration previously in UR6. Our expert also confirmed that a fracture line in a molar tooth is almost never in the plane of an x-ray beam and so a radiograph would not be diagnostic on its own. The ice stick test together with the previous radiographs and clinical observation adequately confirmed the member’s diagnosis.

While the member failed to specifically record that root canal treatment was an option for UR6, he maintained that the patient had been made aware of this option. In our assessment of the case, we considered that even if a court found that the option had not been discussed, it was unlikely that the patient would have chosen this treatment option. She was apparently not in a position to fund ongoing private treatment and her pain was sufficient for her to seek an emergency private consultation on a Saturday afternoon.

We also noted that the patient had previously lost LL6 and UL6.

With the member’s agreement, we strongly denied liability. The solicitors for the patient subsequently confirmed that they would not be pursuing the matter.