This advice sheet has been prepared using guidance from the following documents:
• Professional Standards for Orthodontic Practice, British Orthodontic Society.
• Standards for the Dental Team, General Dental Council.
• Principles of Patient Consent, General Dental Council.
• Consent Tool Kit, British Medical Association.
• Consent, Dental Protection.
• Consent Guidance, patients and doctors making decisions together, General Medical Council.
• Reference Guide to Consent for Examination and Treatment, Department of Health.
• Consent to Clinical Photography, Institute of Medical Illustrators.

1. **What is consent?**
   Consent is a process rather than an event or a signature. This process is the communication of key information to the patient about the proposed treatment and the patient’s response in terms of an informed decision whether or not to proceed.

2. **Does a signature or consent form constitute consent?**
   A signature or consent form simply documents that some discussion about the treatment has taken place. There is no legal requirement to obtain written consent in orthodontics. What is important is the clarity and quality of information provided. Consent forms are therefore evidence of a process, not the process itself. As such, it is essential that any discussions between the clinician and the patient are recorded in the patient notes as well as on a consent form.

   However, written consent is recommended if:
   • The investigation or treatment is complex or involves significant risks (e.g. for procedures involving conscious sedation or general anaesthetic).
   • Providing clinical care is not the primary purpose of the investigation or treatment.
   • The treatment is part of a research programme.

   Procedures in orthodontics where written consent is particularly desirable are joint treatments that involve surgery or complex restorative work. For other procedures clinicians will need to take account of local policy and the perceived needs of the case. Many orthodontists routinely obtain written consent for all treatments and there is much to be said for this practice. If a case goes to litigation, it may be easier to defend where there is a written record of the consent process highlighting the risks and benefits of treatment. Practitioners providing orthodontic treatment under private contracts are well advised to obtain written consent to the treatment and the terms under which it is to be provided together with the anticipated cost of treatment.
3. What are the principles of consent?
The General Dental Council’s Standards for obtaining valid consent is reproduced below (Standards for the Dental Team, General Dental Council, 2013):
• Valid consent should be obtained before starting any treatment or investigation. All the relevant options and the possible costs should be explained.
• The clinician should make sure that patients (or their representatives) understand the decisions they are being asked to make.
• The clinician should make sure that the patient’s consent remains valid at each stage of investigation or treatment.

4. Age and consent

4.1 Aged 18 and over
In England, Wales and Northern Ireland, once a person reaches their 18th birthday, they are assumed to be a competent adult capable of consenting or refusing treatment, unless other factors prevent them from making informed decisions.

4.2 Aged 16 and 17
A child of 16 or 17 can consent to treatment in accordance with the Family Law Reform Act 1969 but a person with parental responsibility can also consent to the treatment of a child aged 16 or 17. If a child of 16 or 17 consents to treatment, consent cannot be withdrawn by the person with parental responsibility.

4.3 Younger than 16
Patients under 16 who understand fully what is involved in the proposed procedure can also give consent. It is important that a child should not feel under duress to accept treatment. Legally a person with parental responsibility can give consent if a child refuses. This would generally be unwise in an orthodontic context as the success of treatment is very dependent on the co-operation of the child. A competent child can in principle consent without the agreement of the parents, but as parental support is also a key factor in the success of treatment, every effort should be made to reach consensus. Although an unaccompanied child may be competent to give consent, it is wise to encourage the child to involve the parents if at all possible, and to give the parents an opportunity to discuss the treatment with the clinician.

For a child under 16 who does not have sufficient understanding to give informed consent, consent is required from a person with parental responsibility.

All mothers have automatic parental responsibility. Parental responsibility rests with both parents, provided they are named on the birth certificate and regardless of whether they are married or not, for children whose births were registered from:
• 15 April 2002 in Northern Ireland.
• 1 December 2003 in England and Wales.
• 4 May 2006 in Scotland.

For children whose births are registered prior to these dates, the father would only have parental responsibility in the following circumstances:

• If he and the mother were married at the time of conception, birth or sometime after; this responsibility is not lost if the mother and father later divorce.
• If he and the mother were never married, but he has a parental responsibility agreement with the mother that is registered with the High Court, or a parental responsibility order from the court.
When a child is adopted, the adoptive parents are the child’s legal parents and automatically acquire parental responsibility. The court will outline who has parental responsibility while the child is subject to a care or supervision order. This could be the father, a guardian or local authority. Foster parents rarely have parental responsibility.

This publication is designed to cover the most common consent issues that a clinician may experience. On occasions, other more complex consenting issues may arise and the reader would be advised to seek professional advice from their defense organisation.

People looking after the child such as child-minders, grandparents or schoolteachers do not automatically have parental responsibility, but parents can authorise them to make medical decisions for the child. Many schools, for example, seek explicit agreement in advance from parents that teachers may consent to any treatment that becomes necessary whilst the children are in their care. A person appointed to be a guardian of a child in the event of the parent’s death is called a testamentary guardian. This appointment is usually executed in the Will of the deceased.

As with other adults, people with parental responsibility can only provide, or refuse, consent if they are thought to be capable.

Parental responsibility can also be granted to other people by the courts, such as a legally appointed guardian.

5. Consenting patients who lack capacity
In the case of patients who lack capacity, the parents can consent for a minor, but not for adults (Mental Capacity Act, 2005). In the latter instance, the clinician has to make a judgment as to whether the treatment is in the patient’s best interests; the views of relatives should be taken into account but they cannot give consent. It is important not to underestimate the competence of patients with a degree of mental incapacity to give valid consent; carers can often advise on the degree of understanding that an individual can achieve.

6. Which member(s) of the dental team should seek consent for orthodontic treatment?
The senior clinician responsible for the patient’s treatment should normally seek consent for orthodontic treatment. Time needs to be taken to explore the patient’s needs and wishes in order to tailor the process accordingly. Consent should also include a discussion of alternative treatment options, including the option of doing nothing and the risks and benefits of each. In complex issues such as orthognathic surgery and orthodontics, the consent process will require several visits over an extended time and be modified for the individual needs of the patient.

6.1 Clinicians in training
The clinician responsible for a case may delegate all or part of the treatment to other members of the team including those in training. The delegating clinician is responsible for ensuring that the person to whom a procedure is delegated is competent to undertake the procedure. When consenting to treatment, patients should be aware if clinicians in training or dental students might be involved in their treatment. An explanation of the need for practical experience during training may well be helpful. Where an additional procedure is undertaken, primarily as a teaching exercise rather than as part of a patient’s treatment, specific patient consent must be obtained.

Orthodontic therapists (OT) are registered dental professionals who carry out certain parts of orthodontic treatment under the prescription from a dentist. GDC Learning Outcomes state that OTs should be able to take valid consent. Treatment planning
is not within their scope of practice and so a discussion of the overall treatment plan and alternative options would be invalid. Consent that OTs can obtain is limited to consent for specific procedures such as taking photographs for records.

6.2 Student training
If students or others are to observe patient consultations or treatment, an explanation should if possible be given to the patient in advance. The patient should feel free to refuse consent to the presence of the observers without detriment to the treatment. Local protocols should be followed regarding the active participation of students in treatment and specific consent sought.

7. Consent and photography
Written consent must always be obtained for any form of visual recording of the patient. The person taking the photographs must always check that the patient understands what they have consented to. The purpose and possible future use of the photographs must be clearly explained to the person, before their consent is sought to take the photograph. Patients should also be made aware that they can withdraw this consent at any time without their care being compromised. For further details on clinical records, please read the British Orthodontic Society’s guidance document, Orthodontic records: collection and management.

8. What factors should be addressed with patients before a course of orthodontic treatment?

8.1 Treatment options
In some orthodontic cases there is only one approach that the clinician would be happy to recommend, and there is little scope for considering other possibilities. However, in other cases, alternative approaches to treatment are possible, sometimes with very different outcomes. In such cases, the risks and benefits of alternate options, as well as the proposed treatment plan should be discussed. Questions should be answered as factually as possible and without bias. Patients wishing to seek a second opinion should feel free to do so. The option of “doing nothing” should also be discussed as part of the consent process.

8.2 Patient commitment
A course of orthodontic treatment involves a prolonged commitment on the part of the patient in order to achieve success. It is essential that patients (and parents as appropriate) understand at the outset, the implications of treatment in terms of regular attendances and the possibility of time out from school or employment, oral hygiene requirements, dietary restrictions, discomfort, extractions, appliances and post-treatment retention. The need to continue regular visits to the family dentist, the predicted active treatment time and the time that retention will be actively monitored should also be discussed. The discussion about proposed treatment time should be tailored to the needs of the individual patient, rather than giving the patient an average treatment time for all patients.

8.3 Benefits of treatment
The likely benefits (or otherwise) in terms of appearance and occlusal function, or other areas (as appropriate to the case) should be explained; care should be taken not to make claims that go beyond the evidence. It should be made clear where uncertainty exists about outcomes or if treatment proposed is ‘non-mainstream’. The possible consequences of not undertaking treatment should also be discussed.
8.4 Limitations of treatment
Patients should be clear about what the treatment will and will not achieve, particularly if the treatment objectives are limited. If the aim of treatment is a compromise rather than an ideal outcome then the patient should be made aware of this. The reasons why the clinician feels that they are unable to achieve an ideal outcome should also be discussed with the patient and documented in the notes. The patient should be given the option of a referral to another clinician who may be able to achieve a more ideal result.

8.5 Risks of treatment
Significant risks for the case in question should be covered, including the possibility of relapse. It is not always possible to be specific about the risks that should be mentioned in any particular case, but from knowledge of the case the clinician has to make a careful judgment of the material risks about which the patient should reasonably be informed before reaching a decision. Mention of any special factors applying to the case should be recorded in the notes.
Following the Montgomery vs. Lanarkshire Health Board case in March 2015, the onus is on the clinician to inform the patient about all the possible risks of a treatment as they apply to that particular patient. It is not acceptable to merely provide patients with data about percentage risk of a procedure in the general population.

8.6 Multidisciplinary treatments
Cases involving both orthodontics and a procedure in an associated discipline need particular care. Ideally a joint consultation should take place so that the patient has the opportunity to discuss the risks and benefits of the overall plan before either treatment is started. If this is not possible, the orthodontist should outline the overall plan but then ask the other clinicians involved to agree the plan before treatment commences. For major surgical procedures a pre-treatment consultation with the surgeon is important. Where extensive restorative procedures are planned, the patient must be fully aware of the long-term implications including the possibility of costs. A consultation with the clinician who will be undertaking the restorative procedures is advisable and reflects best practice. Individual clinicians should obtain consent for their part of treatment.

8.7 Weighing up
The need to balance benefits against risks and drawbacks should be emphasised, particularly in the treatment of milder malocclusions. Patients commonly find some difficulty in reaching a firm decision in the unfamiliar surroundings of a surgery. In such cases it is advisable to let them consider at leisure, with clear arrangements about what they should do once a decision has been reached. Written material may be helpful in supporting the process of reaching a decision. Sometimes a further discussion will be required before a final decision can be reached.

8.8 Retention
Every effort should be made to determine the retention regime and discuss this with the patient and parents before active treatment commences. They should also be aware of the type of retainers to be used, the length of time they will need to wear them and the period of supervision provided. The reasons behind and the risks and benefits of any proposed changes to the proposed or current retention regime should be discussed with the patient before any changes are made. The nature of any charges associated with a patient’s long-term retention requirements should also be explained to them.
9. Does consent need to be reaffirmed?
Where there has been a lengthy delay between the initial consultation and the start of treatment (as for example when a patient has been on a treatment waiting list), or treatment techniques may have evolved reaffirmation of consent is needed.

10. Consent to continuation of treatment
Once explicit consent to an entire course of treatment has been given, the fact that a patient continues to attend for treatment in the normal way can be regarded as implied consent for its continuation. When giving implied consent by attending for subsequent treatment visits, the patient should be aware, at least in general terms, of what procedure is about to be undertaken at that visit.

11. Change of plan
If a change of plan is needed during treatment (e.g. additional extractions or a different type of appliance) the patient should be fully informed of the circumstances and continuation of consent confirmed. Consent for one procedure cannot be assumed to extend to other procedures. Every effort should be made to give patients and parents a realistic proposed treatment time during the initial consent process. If during treatment it becomes apparent that the treatment will take longer than anticipated, the patient and parent should be informed so that they can plan accordingly.

12. Withdrawal of consent
Consent to treatment can be withdrawn at any time, even in the middle of a course of orthodontic treatment. If a patient indicates a wish to terminate treatment, advice should be given to the patient on any likely adverse consequences of a premature termination. If the patient continues to request termination, the operator is obliged to comply and must remove any fixed appliances.

Although the operator would not normally be responsible for the adverse consequences of premature termination in these circumstances, there is a continuing responsibility for the patient’s welfare and measures that may help to improve the outcome (e.g. retention appliances) should still be offered if the operator judges that they are likely to be beneficial.

13. Discontinuation of treatment
Patients wishing to terminate treatment early must accept that they are acting against the advice of the clinician. The risks of continuing treatment, together with the risks of terminating treatment, should be clearly detailed. A signed disclaimer can be useful but not a guaranteed defence. A patient and parent may still argue that they were not fully informed about the consequences of stopping treatment early before they went ahead with the debond. Therefore it may be advisable to delay the termination whilst the patient reflects on the implications of terminating treatment. A clear record in the notes detailing the process and discussion should be made.
Summary
The onus is on the clinician to make sure that the patient and/or parents have understood the information that they have been given and have had the opportunity to ask questions. The recent Montgomery vs. Lanarkshire case means that patients now have the right to all the information about the potential risks of a procedure as they pertain to them as an individual. Remember that consent is a process rather than an event and it is a process of communication. It does not matter how the communication takes place (e.g. verbal, audio and/or visual, written) as long as it is effective. The consent process should be recorded and the most effective place to do this is in the clinical notes.

Note
This advice sheet is based on a current understanding of English Law but users are recommended to seek professional advice in cases of doubt. Some differences are found in Scottish Law and local advice should be sought.

Consent checklist
For you to be able to provide the patient with appropriate information from which they can make a decision, consider the following questions:

1. Have I discussed all the possible treatment options that I am aware of, including the option of doing nothing, with the patient and/or their parents?
2. Have I discussed and documented the risks and benefits of each of these treatment options with the patient and/or parent?
3. What would a reasonable patient expect to be told about the treatment?
4. Are there any particular risks of my proposed treatment plan to this individual patient?
5. What written information will you provide to the patient? (e.g. treatment plans, letters explaining treatment, information sheets.)
6. How can I be sure that the patient has understood the information given to them?
7. If the patient does not understand, for example the patient does not speak the same language, then an interpreter may be necessary.
8. Has the patient been given the opportunity to ask questions to their satisfaction?
9. Be prepared to reassure and take consent over a few visits if needed.
10. Let the patient take the decision.
References:

The Family Reform Act 1969

The Mental Capacity Act 2005

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