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REVIEW

An Overview of Informed Consent in Dentistry in Malaysia

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ABSTRACT

Introduction: Obtaining informed consent from patients is a fundamental legal and ethical element that is required of dental practitioners. From routine procedures such as dental filling or scaling to more complicated procedures such as oral surgeries, it is imperative that patients' informed consent be acquired. Failure to procure a valid consent from patients prior to embarking on any dental treatment may cause several potential legal repercussions against dental practitioners. This paper, thus, seeks to discuss the issue of informed consent with particular reference to dental practice. It begins with an explanation on the laws governing informed consent in Malaysia. Then, an analysis on the ethical aspect behind the need to obtain patient's consent, namely patient autonomy is provided. This is followed with a discussion on the potential legal consequences for failure to obtain informed consent, limiting to civil actions only. **Methods:** This is a descriptive paper that adopts legal doctrinal and qualitative method of analysis. **Conclusion:** The precondition of obtaining patients' informed consent is a fundamental aspect in dental practice both for patients and dental practitioners.

KEYWORDS: Dentistry; medical Law; dental law; ethics; dental negligence; informed consent; patient autonomy; medical paternalism; patient's rights; civil liability

INTRODUCTION

Obtaining patients' consent for any dental treatment is an important legal and ethical requirement. The need for patient's consent is an illustration of a key aspect in medical ethics namely patient autonomy. With the changing times and evolving societal awareness, patient autonomy has triumphed over the long established notion of medical paternalism where doctors were assumed to know what is best for their patients. Long gone are the days where patients would put their utmost trust on doctors to decide for them on the best course of treatments [1]. This change can be associated with an increased knowledge in patients' rights. As succinctly stated in *Montgomery v Lanarkshire Health Board [2015] UKSC 11,* patients now are:

"*...widely regarded as persons holding rights, rather than as the passive recipients of the care of the medical profession. They are also widely treated as consumers exercising choices: a viewpoint that has underpinned some of the developments in the provision of healthcare services.*"

In the light of this, it is imperative for dental practitioners to comprehend the need to obtain a validly informed consent from their patients for every dental treatment offered so as to avoid legal ramifications. This paper, therefore, provides a discussion on the issue of informed consent in dental practice in Malaysia. It begins by explaining the legal position on informed consent in Malaysia. This is followed with an analysis on the ethical aspect behind the need to obtain patient's consent, namely the notion of patient autonomy and the conflict between patient autonomy and medical paternalism. The discussion on the potential legal consequences for failure to obtain informed consent, limiting to civil actions only, are then provided. Dental negligence comes within the purview of medical negligence. Thus, the law on medical negligence, including the law governing the issue of consent that is applicable to medical practice is equally relevant to dental practice. In this paper, however, whenever possible, the law on informed consent presented is applied specifically to dentistry in order to provide dental practitioners with a clearer understanding on this issue.

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MATERIALS AND METHODS

This paper primarily adopts a legal doctrinal and qualitative method of analysis that involves qualitative method of research. Legal and non-legal materials are analysed which involve primary and secondary sources. Examples of primary materials are statutes, case laws and other legal and non-legal literatures. The secondary materials include textbooks, journals and non-journal articles, seminar papers, media reports and many more. Dental literatures are also referred to in order to provide a clearer illustration on the legal issues presented. A comparative method is also utilised in which legal and non-legal materials from other jurisdictions such as United Kingdom are referred.

DISCUSSION

The Law of Informed Consent in Malaysia

Consent is defined by the Malaysian Dental Council (MDC) in its Code of Professional Conduct 2014 as "…the granting to someone the permission to do something they would not have the right to do without such permission" (section 1.4) [2]. There is no specific statute governing consent in Malaysia except the Mental Health Act 2001 which only applies to mental health patients defined in the Act [3] and the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 created under the Private Healthcare Facilities and Services Act 1998 (Act 586) that applies to private healthcare facilities only.

In the light of this lacuna, English common law may be applied by the Malaysian courts pursuant to section 3(1) of the Civil Law Act 1956. In summary, the English common law dictates that an adult patient with sufficient capacity has the right to choose whether to receive or refuse any medical or dental treatment. As seen in Re T (Adult: Refusal of Treatment) [1992] All ER 649 where Lord Donaldson opines that:

"An adult patient who…suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another treatments being offered." (p.653)

Also, the English court in Re MB (Medical Treatment) [1997] 2 F.C.R 541 held that:

"Every person is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted."

Similarly, in *Re C (Adult, Refusal of Treatment) [1994] 1 All ER 819,* a patient's refusal to treatment was upheld by the court on the basis that even though he was a schizophrenic, the patient exhibited sufficient understanding on the nature of the surgery. Hence, the surgery cannot be undertaken without the patient's consent.

In addition, for consent to be legally valid, it must be voluntary and free from any coercion or influence. In Re T (Adult: Refusal of Medical Treatment) [1992] All ER 649, the English court rejected a pregnant woman's refusal for a blood transfusion on the grounds that her decision was influenced by her mother who was a devout Jehovah Witness. On the same note, dental practitioners too, are cautioned not to influence their patients to opt for one treatment over another. According to Reid:

"…it is commonplace for dentists to advise patients with irreversible pulpitis about the options of endodontic treatment followed by crown versus extraction. Were the dentist to claim that the only option is the profitable endodontic/restorative one, and omit extraction from discussion, the informed consent process would be manipulative and paternalistic, effectively obstructing patient participation in her care" [4].

Finally, it is pertinent for patients to be provided with sufficient information on the proposed treatment. Dentists who fail to comply with this condition, may be liable for a claim in negligence as explained later in this paper. The legal requirement of informed consent is closely connected to the notion of patient autonomy which is elaborated below.

Informed Consent and Patient Autonomy

Patients' consent to dental treatments is a manifestation of their ethical rights to have their autonomy respected. Respect for autonomy is one of the main ethical principles enshrined by Beauchamp and Childress. In dealing with issues in medical practice. Beauchamp and Childress explain:

To respect an autonomous agent is at a minimum to acknowledge that person's right to hold views, to make choices and to take actions based on personal values and beliefs." [5]

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Another philosopher, John Stuart Mill, advocates the notion of individual autonomy as he says: *"As it is useful that while mankind are imperfect there should be different opinions, so is it that there should be different experiments of living; that free scope should be given to varieties of character, short of injury to others; and that the worth of different modes of life should be proved practically, when anyone thinks fit to try them. It is desirable, in short, that in things which do not primarily concern others, individuality should assert itself." [6]*

According to Mill, the ability to make one own choices is important as it is through this "different experiments of living" that people discover the way of life that is apt to them. Consequently, even if one's choice is not agreed upon by others, one's autonomy to implement his choices should not be apprehended [6]. In medical and dental practice, a competent adult patient's decision to accept or refuse treatment should be respected in order to protect his autonomy and bodily integrity [7]. The importance of preserving patients' autonomy and self-determination is emphasized by Lord Goff in Airedale NHS Trust v Bland [1993] AC 789:

"the principle of self-determination requires that respect must be given to the wishes of the patient, so that if an adult patient of sound mind refuses, however, unreasonably, to consent to treatment or care by which his life would or might be prolonged, the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests to do."

Furthermore, the House of Lords in an English case of Chester v Afshar [2004] UKHL 41, reiterates the significance of respecting patient's autonomy:

"A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to avoid the occurrence of the particular physical injury of which a patient is not prepared to accept. It also ensures that due respect is given to the autonomy and dignity of each patient." (para 18)

The concept of autonomy, therefore, requires that patients' decision-making to any treatment must be respected [8]. Conti, Delbon, Laffranchi, Paganelli surmise that good dental practice requires a shared decision-making whereby patients are adequately informed about the proposed treatment and the patient takes part in making a decision on the treatment [9]. Thus, obtaining informed consent is deemed as an important legal and ethical duty placed on dental practitioners. The notion of patient autonomy, however, appears to be in conflict with the concept of medical paternalism where doctors are deemed to know what is best for their patients.

Patient Autonomy versus Medical Paternalism

The concept of paternalism arises on the grounds that "doctor knows what is best for patient." [11]. Medical paternalism is defined as "interference by the physician with the patient's freedom of action, justified on the grounds of the patient's best interests" [10]. In simple terms, the concept of medical paternalism justifies interference with patients' autonomy by medical professionals on the basis of patients' welfare. As medicine is a complicated field, doctors are presumed to be in a better position to decide on what is best for their patients. An example of the application of medical paternalism is the concealment of certain information on the proposed treatment due to concerns that the patient might refuse a life-saving treatment or when it is feared that the disclosure of the information would cause other potential adverse consequences [11].

However, with the growing awareness on patients' rights and autonomy, the application of medical paternalism has been challenged. As seen earlier, the notion of patient autonomy requires patients to be sufficiently informed of the treatment offered and the final decision should be made by the patient. This conflicting position between patient autonomy and medical paternalism in the context of informed consent has been the subject of several case laws which are discussed later in this paper.

Informed Consent and The Dentists

It is essential for dental practitioners to ensure that patient's informed consent is properly obtained and this can be achieved in the ways described below.

The Types of Consent

In essence, consent can be procured in three forms namely, impliedly, verbally and in writing. According to the Malaysian Dental Council (MDC) Code of Professional Conduct 2014 [2]:

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"It is accepted that consent is implied in many circumstances by the very fact that the patient has come to the dental practitioner for dental care. There are, however, circumstances where verbal and if appropriate written consent is necessary for investigation and treatment. Consent can only be obtained by a practitioner who has sufficient training and experience to be able to explain the procedure, the risks and benefits and the alternatives."

The three types of consent are elaborated in turn below.

(a) Implied consent

An implied consent can be inferred from the patient's conduct. For example, a patient who walks into the clinic complaining of a fever can be deemed to agree to have his temperature checked together with other related examination such as taking his blood pressure. Also, by offering his arm for an injection, the patient is also considered to have consented to the injection [11]. In dental practice, Rowe describes that an implied consent can be presume when the patient sits on the dental chair with his/her mouth open for a dental treatment [12]. Consent can be further implied when the patient arranges and attends his dental appointment, offers information or answers the dentist's questions and willingly submit to physical examination without any objection [13]. Generally, an implied consent is assumed "by the demeanour of the patient and is by far the common variety of consent in both general sense but not to procedures more complex than inspection, palpation, percussion and auscultation" [13]. Similarly, the Malaysian Dental Council (MDC) also cautions that: "It must be remembered that a patient who walks into a dental surgery gives implied consent only limited to clinical oral examination, consultation and diagnosis." (section 1.4) [2]. In other situations, consent may be suitably obtained verbally or in writing.

(b) Verbal consent

Alternatively, consent can also be verbally obtained from the patient. The acceptability of a verbal or oral consent should be limited to situations where "…the treatment is likely to be more than mildly painful, when it carries appreciable risk, or when it will result in diminishing of a bodily function" [13]. Verbal consent may, however, be questioned or cause problems if the patient later denies giving his consent [14]. The MDC Code of Professional Conduct 2014 advises that:

"*Verbal consent is acceptable when the procedures are limited to treatment of the problem presented by the patient. It is necessary for a witness to be present during the explanation and the giving of consent."* (section 1.4) [2]

Dental practitioners are, therefore, recommended to verify and record the patient's consent in the patient's record [13]. Moores, Miller and Henderson further suggest that all discussions between the dentist and the patient, particularly on the risks involved, should be clearly recorded in writing. This record should also contain the possibility of an alternative treatment and any concerns raised by the patient [15].

(c) Written consent

In more complicated procedures or surgeries, consent should be obtained in writing. Regulation 47(1) and (3) of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 expressly provides that:

"(1) A licensee or person in charge of a private healthcare facility or service shall obtain or cause to be obtained valid consent from a patient before any procedure or surgery is carried out on the patient.
(3) Consent obtained or caused to be obtained under this regulation shall be in writing."

Regulation 47(4) further stipulates that failure to comply with the above requirement is an offence which shall be punishable to a fine not exceeding RM10,000 or to imprisonment for a term not more than three months or both.

In dental practice, a written consent is usually required in cases of "extensive intervention involving risks where anaesthesia or sedation is used, restorative procedures, any invasive or surgical procedures, administering of medications with known high risks and so on" [16]. As stated in the Malaysian Dental Council's Code of Practice 2014:
"Written consent is consent for treatment signed by the patient or the legal guardian, and duly countersigned by a witness. Dental practitioners shall obtain valid

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consent prior to carrying out treatment. For consent to be valid:

a) the practitioner should explain to the patient the treatment proposed, the risks involved in the treatment, advantages and limitations of that treatment, and alternative treatments and costs. In other words, the consent must be informed. The practitioner should also not give guarantees or make unreasonable promises about the outcome of treatment.
b) for minors (below age 18 years), written consent must be obtained from the parents or legal guardian.
c) if general anaesthetic or sedation is to be given, all procedures must be explained to the patient. The onus is on the dental practitioner to ensure that all necessary information and explanations have been given either personally or by the anaesthetist. In this situation written consent must be obtained." [2]

Overall, Baxley offers a lengthy guide for dental practitioners:

"Any procedure that is "invasive or irreversible" requires informed consent. The fact that a patient goes to an office for an exam implies that he or she wants the doctor to perform some type of clinical exam to determine what might be needed, but most dentists take for granted the fact that more than 90% of their procedures are surgical in nature. All procedures, from a simple buccal pit restoration to the removal of a complicated, full boney, impacted third molar, require an irreversible change to bodily tissues with the risk of some type of complication or unwanted side effect. Even minor occlusal/incisal adjustments can affect the surrounding dentition, cuspid rise, masticatory function, or TMJ stability. The mouth is an extremely dynamic environment, subject to the forces of the tongue, lips, cheeks, and teeth. Any change to that environment, even with the best of intentions by the practitioner, may lead to unwanted results, and those possibilities need to be presented to the patient and documented in writing." [17]

Nevertheless, Puteri Nemie rightly points out that "a signed consent form is merely evidence that the patient signed the form but does not mean that he necessarily understood the significance or implications of the treatment, which is being proposed in the form" [11]. The fact that there is a signed written consent is not a conclusive proof of a legally valid consent. The patient may still challenge the consent on the reason that he was not provided sufficient information or lack the capacity to consent [11]. Where consent is not properly or validly obtained, dental practitioners may be subjected to legal actions explained below.

Potential Civil Liabilities for Treatment Without Valid Consent

Failure to conform to the obligation to obtain a valid consent exposes dental practitioners to legal actions in civil and criminal law. This paper, however, focuses on the potential civil actions that may be instituted against dental practitioners for administering dental treatments without a valid consent. The possible civil legal actions that may be constituted against a dentist for acting without a valid consent include:

(a) a claim for battery under the law of tort; or

(b) a claim for negligence under the law of tort;

In what follows, these courses of action are considered in turn.

(a) Battery under the law of tort:

Battery can be explained as "the intentional and direct application of force to another person without that person's consent. This touching need not necessarily involve violence" [19]. The basis for a claim under tort law for battery was illustrated in Airedale NHS Trust v Bland [1993] A.C 789 where Lord Keith held that:
"It is unlawful, so as to constitute both a tort and the crime of battery, to administer medical treatment to an adult who is conscious and of sound mind, without his consent."

Civil suits for battery are confined to situations where the patient did not consent to the treatment administered. The patient must have consented to the particular treatment offered for the consent to be valid. If the patient consented to a different treatment than that performed by the dentist, then the said consent is not valid and the dentist may be held liable for unlawful touching [7]. For example, in the practice of dentistry, if the patient only consented to the extraction of one tooth but the dentist also extracted the adjacent tooth, then latter act may be deemed as unlawful. In Appleton v Garret [1996] 5 PIQR P1, an action was commenced

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against a dentist for performing unwanted and unnecessary dental treatments on his patients without their consent. The necessity of the treatment was not informed to the patients by the dentist as he anticipated that the patients would not have consented to the treatments had they been informed about those treatments. Further, in a case that was cited by the court in Chatterton v Gearson [1981] QB 432, a patient was admitted for a tonsillectomy surgery but instead, a circumcision was mistakenly performed on him. The court held that the course of action for this situation should be an action for trespass to person or battery.

However, Tengku Azira Tengku Zainudin et. al. observes that civil actions against doctors mostly lies on the failure to provide adequate information on the nature and risks associated with the treatment given [3]. In this circumstance, the consent obtained from the patient is deemed as valid but legal action can be brought under the tort of negligence for breach of doctors' duty to warn patients of the risks involved. Herring also explains that there is a difference between battery and negligence whereby for the former, the patient did not consent to the bodily touching. For the latter, although patient may have given consent, the doctor is still negligent for failing disclose material information regarding the treatment [18].

(b) Negligence under the law of tort:

In the event that a patient's consent to a medical or dental treatment has been deemed as valid, another alternative for patients is to sue for negligence for breach of duty to advise patients on the material risks related to the proposed treatment [7]. The duty of care held by dental practitioners is similar to that of other healthcare professionals as dental negligence falls within the ambit of medical negligence. In a nutshell, as with other healthcare professionals, dental practitioners owe a duty of care in diagnosing, advising and treating patients [20][21]. Breach of the duty to advise patients of the risks involved in a dental treatment may constitute a tort of negligence on the part of the dentist. In Lechemanavasagar a/l S Karuppiah v Dr Thomas Yau Pak Chenk & Anor [2008] 1 MLJ 115, the High Court vehemently held that:

"…a medical practitioner is duty bound to inform the patient of the risk involved in any proposed treatment to enable the patient to elect to proceed with the treatment or not…even if a doctor in the course of giving treatment to the plaintiff has followed the standard procedures acceptable to a group of medical practitioners and would have passed the Bolam test, he is not discharging his duties if he fails to explain the risk to the patient to enable the patient to elect to proceed with the treatment or not."

Malaysian courts have adopted the standard of care established in an Australian case, *Rogers v Whitaker [1993] 4 Med LR 79* on the duty to advise patients of material risks inherent to the treatment. In *Rogers v Whitaker*, it was held that:

"The law should recognise that as doctor has a duty to warn a patient of material risks inherent in the proposed treatment. A risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is, or should reasonably be aware that the particular patient, if warned of the risks would be likely to attach significance to it."

The Federal Court in *Zulhasnimar bt Hasan Basri v Dr. Kuppu Velumani P & Ors [2017] 5 MLJ 461* explains the justification for adopting the test in *Rogers v Whitakers* for the duty to disclose risks:

"On the other hand, different consideration ought to apply to the duty to advise of risks as opposed to diagnosis and treatment. That duty is said to be noted in the right of self-determination. As decided by the Australian High Court in Rogers v Whitakers and followed by this court in Foo Fio Na, it is now the courts' (rather than a body of respected medical practitioners) which will decide whether a patient has been properly advised of the risks associated with a proposed treatment. The courts would no longer look to what a body of respectable members of the medical profession would do as the yardstick to govern the standard of care expected in respect of the duty to advise." (p.473)

In discharging this duty of care in advising patients of material risks involved in a dental treatment, the law places the obligation on dental practitioners to reasonably anticipate and understand the patient's position. Dental practitioners should be able to predict the type of risks that the particular patient would find as material or significant by taking into consideration the

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patient's situation such occupation, age etc. and inform the patient accordingly. In oral surgeries, for instance, dental surgeons must identify the potential risks and disclose them with their patients before the surgery. These risks such as the possibility of nerve injury on a particular patient's career must be informed to the patient along with other risks such as pain, swelling, bleeding and infection [15].

Other than that, it is equally pertinent for oral surgeons to inform patients of other possible option or alternative treatment available to enable the patient to give an informed consent for the surgery. In a surgery for the removal of wisdom teeth or third molars for example, if the potential risk of nerve injury may be alleviated or avoided by performing coronectomy procedure, then failure to provide this option exposes the oral surgeon to a claim in negligence [22]. An example can be seen in the United Kingdom where it was reported that a patient suffered permanent damage to his right inferior dental nerve and the left lingual nerve during a surgery to remove two lower wisdom teeth. It was alleged that the patient's informed consent was not obtained as the patient was not asked to undergo a cone beam CT scan and followed by a coronectomy to avoid the nerve damage [23]. In Norizan bt Abd Rahman v Dr Arthur Samuel [2013] MLJU 81, the High Court allowed the plaintiff's claim for negligence against the defendant doctor on the grounds that the defendant failed to adequately inform the plaintiff of the risks associated with proposed treatment. The plaintiff averred that she would not have consented to the treatment had she been informed of the risks involved and would have elected for an alternative treatment instead.

Baxley, therefore, rightly stipulates that since dental practitioners are experts in their field, they have the duty to educate their patients on the proposed treatment or other available treatment and this should be done in a way that can be understood by the patient [17]. Baxley continues by giving an example of a general practitioner in the case of an extraction of tooth and the available options to the patient:

"For example, a general dentist must discuss the option of implants as well as bridges, flippers, and partial dentures, even if that dentist does not place or restore implants, if he plans to remove a tooth or two on the lower right quadrant. The patient must understand not only the importance of replacing the extracted teeth but all of the available options to do so as well" [17]

Likewise, it is also important for dentists to inform or warn the patients of the potential consequences of non-treatment. Although a patient's right to refuse treatment is legally protected by the law as seen in Re T (Adult: Refusal of Treatment) [1992] All ER 649, such a decision must be based on sufficient information and understanding on its possible consequences. Patients with dental phobia for example, are likely to refuse treatments at the initial stage [24]. Hence, dentists must be vigilant in finding ways to effectively communicate with these patients so as to ensure that they have sufficient understanding of their condition and proposed treatments.

Baxley offers this example: a patient seeks treatment for a tooth ache but the dentist also discovered the existence of a carious exposure on a lower left first molar. According to the dentist's diagnosis, a root canal treatment accompanied by full coronal restoration with a crown is necessitated [17]. The patient, however, refuses the root canal treatment due to fear of pain. If the dentist simply accepts this refusal on the grounds of respecting patient's wishes and only extracts the affected tooth, he may be liable in negligence for failing to adequately advise the patient of the repercussions of not having a root canal treatment. The dentist in this case, should have explained to the patient that "the molar in question was the last periodontally stable tooth in the quadrant, leaving the existing lower removable partial denture with no anchoring abutment on the left side after the extraction" [17]. Later, when the patient puts the lower partial back into position, he discovers that it is unstable when speaking and chewing and was advised by another dentist that he now requires a lower denture or implants or a combination of both. The patient typically responds that "Had I known that I was going to lose my partial, I would have most likely gone ahead and done the root canal to save the tooth" [17]. In this scenario, the dentist may be liable for a claim in negligence for failure to disclose sufficient or material information or risks to the patient. This example illustrates the importance of disclosing all relevant information pertaining to the patient's condition, suggested treatment, available options and the potential consequences for refusing treatment.

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CONCLUSION

Obtaining informed consent from patients is the cornerstone of good dental practice. Although most dental procedures are seen as typical or routine in nature, the necessity for informed consent should not be undermined by dental practitioners. As illustrated in this paper, the need for consent is vital for both patients and dental practitioners. For the former, obtaining informed consent enhances their autonomy and protect their bodily integrity. For the latter, the need for a valid consent is crucial as a shield towards potential legal implications in the event of the occurrence of an untoward incident during the treatment. Dhingra and Anand eloquently conclude that in the event of the occurrence of an untoward incident during a dental treatment, a valid consent could serve as evidence that the incident was a foreseeable risk that has been explained to and accepted by the patient [25].

Conflict of interest

Authors declare none.

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Authors' Contribution

All authors conducted the audit, wrote, edited and approved the final version of the article.

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