Informed Consent

Dental science has made marvelous progress in restorative and reconstructive procedures. The ability to reconstruct instead of repair or replace has greatly enhanced the prosthodontist's ability to treat partially or completely edentulous patients. As a result, treatment planning options are exponentially more complex than they were even a decade ago, and this complexity has brought new responsibilities. Sometimes it is difficult to decide what is best for the patient and how far one should go in reconstruction as opposed to accommodating to the existing limitations. Prosthodontists can seek the aid of skilled periodontists to reconstruct residual ridges prior to placing a fixed prosthesis or to move receded gingival tissues more coronally to cover exposed root surfaces. Implant dentistry has completely changed a prosthodontist's approach to treatment planning and has greatly expanded the options available to the patient. When presenting such options to a patient, the demands of informed consent are encountered and it may be difficult to adequately make such disclosures.

When the classical Brånemark research was presented, the percentages for success were documented, accepted, and cited to patients. It is well understood that that research related to the classical anterior mandibular implant-supported prosthesis opposing a maxillary complete denture. As the anterior maxillae, the posterior mandible, and later the posterior maxillae including the tuberosity areas became implant sites, the reports regarding success have been less extrapolable to specific patient treatment plans. With the multiplicity of commercial systems available for implant selection and restoration, the citation of specifically applicable and relevant research data by which to predict success has become exponentially more difficult.

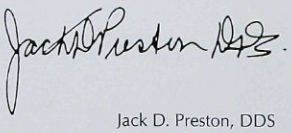
Similarly, reports of techniques for residual ridge reconstruction prior to placement of a fixed partial denture and coronal repositioning procedures have filled the dental literature. Most are technique descriptions with limited controls and small study populations, although a few well-designed studies have been reported. How then does one use such literature in devising an informed consent document? The patient is entitled to know the advantages and disadvantages of any treatment plan. It has been well established and accepted that the treating dentist must offer the patient valid options and offer some prediction of the success obtainable with each option. This has become a difficult encumbrance, and citing directly applicable studies is problematic.

The point is that as complex as providing a patient informed consent for care might be, the patient is entitled to a lucid and honest presentation of facts (or what is currently accepted as fact). These facts must include the revelation that the options for sophisticated care are available, whether or not the clinician is capable of or chooses to provide them, and that while such procedures may be available, and may be beneficial, they may not be essential. Sometimes we become so enamored with the potential to provide sophisticated services, we might lose sight of whether the procedure is being done for the patient or for the practitioner. Economic benefits to the care provider aside, the sheer challenge and pleasure of doing complex procedures might sometimes color the question of what is best for the patient.

The manner in which data are presented to patients is also important. If a procedure has been shown to have a 95% success rate, it must be pointed out that this means there is a 5% failure rate. How many metal ceramic crowns would be placed if there were a predictable 5% failure?

Informed consent has indeed become a complex and sometimes nebulous responsibility. Nonetheless, it is an obligation that cannot be taken lightly, nor can it be set aside with only superficial consideration. Increasing complexity in therapy not only taxes the skills of the care provider, it complicates the open communication between the therapist and the patient. It mandates continued understanding of the current literature, and demands the practitioner be perceptive in ascertaining the validity and relevance of the data reported.

As with other procedures, honest discussion of the limitations of the extent of scientific knowledge is much better than overly optimistic prognostication of the results of the recommended therapy. Informed consent may do more than inform the patient; it is a continuing reminder of the fallibility of any care provider. Well-presented informed consent discussion also reminds the therapist of the ethical, legal, and moral obligations that attend patient care and the limitations of even the simplest procedure.



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