INFORMED CONSENT: A COMPARATIVE STUDY OF ATTITUDES AMONG PEDIATRIC DENTISTS AND TRIAL ATTORNEYS IN INDIANA

by

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INTRODUCTION

The doctrine of informed consent is in a state of development and change. Physicians, dentists and attorneys are attempting to adapt to the non-uniform fabrication of new doctrines throughout the United States. Each state has its own set of laws and every physician and dentist should comply with them.

It is a mandatory and complex task for the pediatric dentist to conform to the doctrine of informed consent. Failure to notify every patient, parent or guardian of the right to an "informed" decision before treatment begins compromises the practice of pediatric dentistry, and invites malpractice litigation. Furthermore, pediatric dentists and trial attorneys probably do not agree on the type of consent required for specific dental procedures. The dichotomy between the pediatric dentist and the trial attorney, with respect to background education on the doctrine of informed consent and the type of informed consent required for specific procedures, contributes to a lack of professional communication between the attorney, the pediatric dentist and the court. Consequently, there is an increased likelihood of malpractice litigation.

This study was designed to compare and analyze the viewpoints of Indiana pediatric dentists and trial attorneys concerning the doctrine of informed consent.

The purpose was to provide insight on how pediatric dentists obtain informed consent, on how trial attorneys recommend obtaining informed consent, and on changing trends in the pediatric dental office with regard to the doctrine of informed consent. The ultimate goal was to acquaint each of the two professional groups with the views of the other concerning the doctrine of informed consent, and to raise the level of awareness of the doctrine among pediatric dentists.

REVIEW OF THE LITERATURE

Informed consent litigation is the fastest growing area in malpractice litigation.[1] Since 1950 there has been an upward trend of dental malpractice suits filed in the United States.[2] Curley[3] recently stated that today's dentist must use a sword and shield in the legal arena. The sword is effective practice management, and the shield is the dentist's records, including documentation by means of radiographs and informed consent. The first documented case of a dentist being sued for lack of consent, after the extraction of a third molar, was in the 1916 case of Rosenthal v. Hasbrouck.[4] The burgeoning malpractice market has made greater attention to this subject [informed consent] mandatory for the dental profession.[5] As a matter of fact, through the action of informed consent, the judicial system is encouraging patients to become more responsible by getting them actively involved in the doctor-patient decision making process.[6]

In 1976 it was reported that over the past several years there had been an increase in the number of cases related to consent.[7] Savage[8] reported that of the 50 courts publishing informed consent decisions during 1980-1981, only one involved dentistry. The LeBeuf v. Atkins[9] case involved a dentist who injected lidocaine

into a patient with a history of hypertension without providing information on the material risks of such a procedure. Consequently, the patient suffered a stroke and sued the dentist for lack of informed consent. The Court of Appeals ruled that the doctrine of informed consent requires a dentist to inform the patient with a history of hypertension of the vasoconstrictive effect of local anesthetics such as lidocaine.

To survive the malpractice crisis, dentists must have a thorough understanding of informed consent from a doctor-patient viewpoint and from the legal viewpoint. The Counsel on Insurance[10] for the American Dental Association stated that:

> It [informed consent] is a vital part of establishing rapport with the patient. Informed consent promotes an ongoing dialogue by removing barriers to communication while decreasing the patient's anxiety. It also demonstrates that the treatment is being personalized to the patient's needs. By encouraging questions, informed consent allows patients to have an important part in controlling their own therapy. Furthermore, it is intended to uncover preconceived ideas or unrealistic treatment expectations the patient may have before treatment is started.

From a legal point of view, Stone[11] stated:

> The traditional doctor-patient relationship is seen by lawyers as one in which the doctor and the patient are unequal bargaining partners in a contract for services. It is the doctor's special knowledge that creates the advantage. Informed consent is meant, then, to force the doctor to give the patient knowledge that will make him or her an equal bargaining partner. Thus, informed consent is meant to transform the essence of the doctor-patient relationship from status to contract.

Therefore, having a clear understanding of the doctrine of informed consent, and adhering to the doctrine, represent the best strategy in the preventive approach to the risk of malpractice suits.[12]

A major problem facing dentists is the presence of a gap between the legal doctrine, the language provided in court opinions and clear, concise communication between dentists and attorneys. The difficulty of closing such a professional gap increases the problem of establishing guidelines for obtaining informed consent from patients.

Pekarsky[13] has attempted to bridge the gap in his text entitled, Dental Practice for Trial Lawyers. The purpose of the text is to offer attorneys a basic knowledge of the general practice of dentistry, its procedures, and an introduction to the dental specialties. The author, a dentist, has tried to provide the attorney with a better understanding of the practice of dentistry. He gives the reader the following light comment on the text: "The oral cavity is the lawyer's most valuable asset; he should know more about it."

To decrease the communications gap between professions, dentists need to increase their knowledge of the American judicial system. Sheppard[1] states that many practitioners scoff at the legal requirements of the doctrine of informed consent. They ignore the fact that a great number

of court decisions and laws require that the patient give informed consent. McCarthy[14] commented that:

> To the dental practitioner as yet uninitiated to the courtroom, and to the predoctoral or auxiliary student, the doctrine of informed consent and the various records and suggested policies must appear to be utterly incredible. Yet enormous efforts by the plaintiff's attorney to achieve big-dollar awards must be met by equal effort on the part of potential defendants. The doctor who innocently places his or her faith in total devotion to the highest quality of patient care, and who does not practice defensively, is headed for a very rude awakening.

It is of utmost importance that the dental practitioner realize that American jurisprudence is based upon an adversarial system.[13]

Curran[15] stated that the doctrine of informed consent has become an area to be feared by every practicing physician and every medical research investigator. Moreover, Curran feels that it is important to realize that the law has the upper hand; within the clinical transaction, there is really no way to compromise the legal demands set forth: the law requires good quality of care and a free, highly informed consent.

Attention to informed consent cases is on the increase. Gwilliams[16] wrote that "a dental malpractice case is nothing more or less than a nitty-gritty little medical malpractice case. It has all the legal problems of a medical malpractice case and more,..." He advises trial attorneys to consider pursuing dental malpractice suits

because "Dentists are usually more quick to criticize their fellow colleagues than physicians" and it may be easier and less expensive to obtain experts in the dental field. He continues to alert trial attorneys to the fact that dental informed consent cases may be easier to prove than in other fields since, "dentists don't usually have adequate written consent forms for elective procedures, and records are extremely sketchy."

Since informed consent is in a state of flux, the prudent dentist should obtain informed consent for any treatment that might be considered significant or objectionable to the average patient, parent or legal guardian; in the practice of pediatric dentistry, a number of techniques fall into this category, especially hand over mouth exercise, restraining devices and physical restraint by dental personnel.[17]

Development of the Doctrine of Informed Consent

The doctrine of informed consent arose from the law of consent. The law of consent requires the practitioner to obtain a patient's authorization before treatment begins. English courts have long recognized that a physician's authority to treat his patient must be founded on consent.[18] In the 1767 case of Slater v. Baker,[18] the court noted: "It is reasonable that a patient should be

told what is about to be done to him, that he may take courage and put himself in such a situation as to undergo the operation." Without a patient's authorization for treatment, a practitioner may be guilty of a tort, that is, a battery. A patient who receives treatment without giving the practitioner permission to treat may be in a position to file a lawsuit for damages against the practitioner for battery.

The first case in which a physician was found guilty of a battery was Mohr v. Williams[19] in 1905. The patient had consented to a surgical procedure on her right ear, but the physician re-evaluated the left ear in the operating room, found that its condition was worse, and proceeded to operate on the left ear instead. The Minnesota Supreme Court provided the following opinion:

> Under free government, at least, the free citizen's first and greatest right, which underlies all others - the right to the inviolability of his person; in other words, the right to himself - is the subject of universal acquiescence, and this right necessarily forbids a physician and surgeon, however skillful or eminent...to violate, without permission, the bodily integrity of his patient... The patient must be the final arbiter as to whether he will take his chance with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal right.

The second case in United States history where a patient sued a physician for battery was the 1914 case of Schloendorff v. Society of New York Hospital.[20] The New York Supreme Court found the physician guilty of battery

and provided the now famous opinion and the basis of the modern theory of consent:

> In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every person of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.

In later years the courts began to view the law of consent differently. Not only did the practitioner have to obtain consent, but the consent had to be informed.

The first case to deal with the duty of providing information on the material risks of the operation was Twombly and wife v. Leach in 1853.[21] This marked the beginning of the Professional Practice Standard for disclosure.[22] The 1957 case of Salgo v. Leland Stanford Jr. University Board of Trustees[23] is credited with prompting adoption of the informed consent approach. The California appellate court found that:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.

In 1960 the landmark case of Natanson v. Kline[24] expanded and clarified the 1957 Salgo[23] decision. The Kansas Supreme Court placed great responsibility on the physician by stating: "The physician should make a substantial disclosure to the patient prior to treatment or risk liability."[24] Murphy[22] titled this case the touchstone

of the Professional Practice Standard and the court formulated the duty as follows:

> [the duty] is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances. How the physician may best discharge his obligation to the patient in this difficult situation involves primarily a question of medical judgment. So long as the disclosure is sufficient to assure informed consent, the physician's choice of plausible courses should not be called into question if it appears, all circumstances considered, that the physician was motivated by the patient's best therapeutic interests and he proceeded as competent medical men would have done in a similar situation.[24]

Over the next decade the majority of courts adopted the views of Salgo and Natanson. It was not until the early 1970s that the doctrine of informed consent became significant. The cases of Canterbury v. Spence,[25] Cobbs v. Grant[26] and Wilkenson v. Versey,[27] all decided in 1972, made a tremendous impact on the Professional Practice Standard by shifting the standard of professional performance to the Materials Risk Standard. The scope of the duty to disclose material risks shifted from the perspective of the Professional Practice Standard to the more difficult Material Risks Standard; all risks potentially affecting the decision [to accept treatment] must be unmasked.[25] The patient's right to know created an increase in informed consent litigation throughout the country. The court defined a material risk in the following manner:

> In broad outline, we agree that a risk is thus material when a reasonable person, in what the

> physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forgo the proposed therapy. The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of harm threatened. A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summon discussion with the patient.[25]

At the same time, the Joint Commission on the Accreditation of Hospitals,[28] and other regulatory agencies, adopted the doctrine of informed consent.

In 1972 the American Hospital Association formulated a Patient Bill of Rights[29] which stated:

> The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.

Since the 1970s more states have adopted the Materials Risk Standard. The number of lawsuits alleging lack of informed consent has increased. Even more common, patients

tend to automatically add the lack of informed consent as the second cause of action to the malpractice suit's first cause of action, negligence.

Since the 1914 decision in the Schloendorff v. Society of New York Hospital case,[20] the debate has continued as to whether a lack of informed consent is an act of battery or an act of negligence. Many court opinions have held that the earlier definition (that a lack of informed consent is battery) is obsolete. An increasing number of courts are now placing the lack of informed consent into the category of malpractice, that is, an area of negligence law.

Whether a court considers the lack of informed consent as battery or negligence is of utmost importance to the plaintiff and the defendant. The classification as battery or negligence affects the statute of limitations, the measure of damages and the elements of proof.

As the doctrine of informed consent developed, the majority of jurisdictions have required the practitioner to disclose sufficient information to the patient so that the patient can make an informed decision. Most courts have agreed that the practitioner is required to disclose the nature and purpose of the proposed treatment, its risks and consequences, the alternative courses of treatment and the risks of refusing the proposed treatment.

The requirement that the practitioner must disclose information to the patient is complicated by the ambiguity as to how detailed the disclosure should be. The majority of litigation due to a lack of informed consent is centered on the failure to explain to the patient the relevant risks of the proposed treatment plan. The issue becomes even more complicated by the wide range of risks that exist for different treatment approaches/options. The risks may range from minimal to serious and from common to rare.

To further confuse the issue, courts either apply the Professional Practice Standard or the Material Risks Standard. Bailey[5] stated:

> The decision by a court to adopt the professional standard test or the material risk approach has a major impact on the course of an informed consent case. A court's adherence to the materials risk approach generally makes it easier for a patient to prevail because the patient need not produce expert testimony.

Unfortunately, the dentist's duty to disclose remains unresolved in many states. In the majority of states a dentist is required to disclose information that would fulfill the Professional Practice Standard test. Bailey[5] summarized the duty to disclose thus:

> In most states, a dentist is obligated to supply patients with the same information that would be provided by a reasonable dentist in similar circumstances; specialists are held to the standards of other practitioners in the same specialty.

For a plaintiff to win informed consent litigation in states adhering to the Professional Practice Standard

requires that the plaintiff provide expert testimony that will establish a standard of dental practice. If the plaintiff does not clearly establish a professional standard of practice, the plaintiff may lose the case.

A minority of states have adopted the Materials Risk Standard. Moreover, the 1972 decisions of Canterbury v. Spence,[25] Cobbs v. Grant[26] and Wilkenson v. Versey[27] further influenced many courts around the country and, consequently, more states have adopted the Materials Risk Standard. Hagan[17] states that the Materials Risk Standard focuses on the informational needs of the average, reasonable patient rather than on professionally established standards of disclosure. A practitioner may be held liable if the patient, parent or guardian did not receive all of the information that was material or consequential to their decision to accept or reject proposed treatment. However, failure to disclose the required information to a patient does not automatically provide the patient with the opportunity to file a lawsuit for lack of informed consent. The patient must prove causation and injury.

As required in a negligence suit, the patient must have been injured by the treatment, must have been injured by the non-disclosed risk of treatment or non-treatment (proximate causation), and must prove that if a full disclosure of information had been provided, he would have refused to consent to treatment ("but for" rule).[30] If the

plaintiff fails to prove both components of causation, he will be denied recovery for negligence even if the duty to disclose was not provided to the plaintiff.

The courts have applied the "objective" or the "subjective" test when hearing the issue of causation in informed consent litigation. The "objective" test requires proof by the plaintiff that a reasonably prudent person would not have consented to the procedure had he known the risks. The "subjective" test requires that the plaintiff would not have consented to the procedure had he known the risks and available alternatives.[31]

The majority of legal opinions have chosen the objective test.[26,32] Supporters of the objective test feel that the reasonably prudent person should determine the outcome of informed consent litigation and not the plaintiff in the case before the court. Still, a number of courts have applied the subjective test.[27,33,34] The subjective test appears to give the individual his right to self-determination. The Oklahoma Supreme Court, in Scott v. Bradford,[33] found that:

> [T]o the extent the plaintiff, given an adequate disclosure, would have declined the proposed treatment, and a reasonable person in similar circumstances would have consented, a patient's right to self-determination is irrevocably lost.

Many supporters of the subjective test concur with this court opinion and agree that health professionals can pre-

vent malpractice actions that deal with informed consent by adequately informing each patient as required by law.

On the contrary, many feel that the subjective test is second best to the objective test. The opinion of Canterbury v. Spence[25] stated that:

> In our view, this [subjective] method of dealing with the issue on causation comes in second-best. It places the physician in jeopardy of the patient's hindsight and bitterness. It places the factfinder in the position of deciding whether a speculative answer to a hypothetical answer is to be credited. It calls for a subjective determination solely on testimony of a patient- witness shadowed by the occurrence of the undisclosed risk.
>
> Better it is we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance. If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not. The patient's testimony is relevant on that score, of course, but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the factfinder's belief in its reasonableness, the case for a wholly objective standard for passing on causation is strengthened. Such a standard would in any event ease the factfinding process and better assure the truth as its product.

There are exceptions to the duty to disclose. A health professional need not disclose a risk if it can be shown that the patient was actually aware of the risk,[25] if the existence of the risk was a matter of common knowledge, so that the awareness may fairly be imputed to the patient,[27] if the risk was not generally known to the

medical community at the time the operation was properly performed,[35-37] if the risk exists only when the operation is improperly performed,[38] or if the patient has requested that he not be informed.[26]

The law of consent allows the waiver of consent under specific circumstances. The physician is not obligated to disclose information that the patient does not wish to hear. In the opinion of Cobbs v. Grant[26]: "[A] medical doctor need not make disclosure of risks when the patient requests that he not be so informed." Another defense for not complying with the informed consent requirement is the existence of a medical emergency. A medical emergency exists when "the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment."[25] The emergency does not have to be life-threatening, only that time is of the essence and the potential harm to the patient is more than trivial. In such circumstances, the practitioner cannot rely on the medical emergency exception if he has the opportunity to converse with either the patient or the patient's family.[39,40]

A third exception to the informed consent requirement relates to the discovery of an unanticipated condition during a surgical procedure. If a patient is under general anesthesia and the surgeon discovers an unanticipated condition that requires treatment, the surgeon may opt to treat

the condition. This exception applies only when the condition is unanticipated, even if the condition is not life-threatening.

A health professional may apply therapeutic privilege and withhold material information from his patient if the practitioner believes that the patient's physical or mental health would suffer if the patient was made aware of the material information. The development of therapeutic privilege may have originated from Salgo v. LeLand Stanford Jr. University Board of Trustees[23]:

> At the same time, the physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient presents a separate problem, that the patient's mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.

Therapeutic privilege was first clearly enunciated in the case of Natanson v. Kline,[24] in which the court stated that a physician would have a privilege not to disclose a risk that "could so alarm the patient that it would in fact, constitute bad medical practice."[22]

The use of therapeutic privilege is controversial because health professionals may try to circumvent the duty to obtain informed consent by a defense of therapeutic privilege. Claims by practitioners that they withheld informed consent to protect their patients are usually questioned by courts and juries. The use of therapeutic privilege is rarely successful in informed consent litigation. Murphy[22] advises that:

> ...if one is convinced that a patient should not be informed of risks because of therapeutic reasons, it would be well to have a second opinion; and clear, good notes should be made so that the assertion of therapeutic privilege does not seem to be hindsight.

Competent patients have the right to refuse recommended treatment, alternative treatment or all treatment. They also have the right to withdraw consent for treatment at any time. The ability of the patient to competently refuse to consent, or to withdraw consent, depends on the facts surrounding the case. If a patient refuses treatment, the practitioner should provide an informed refusal form. Failure to provide an informed refusal of treatment can result in being found negligent.[41] A signed release should be obtained from the patient and made part of the patient's record. If the patient refuses to sign the informed refusal, a statement to this effect should be entered into the record. The right to refuse treatment is highlighted in the case of Natanson v. Kline:[24]

> Anglo-American law starts with the premise of thorough-going self determination. It follows

> that each man is considered to be master of his own body, and may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment.

However, there are limitations to the right to refuse treatment. If the patient's right to self-determination affects the rights of other persons, the health of the public, or interferes with the interests of the state, a patient may lose the right to refuse treatment. Examples include cases when contagious disease threatens the health of the public,[42] when a patient is pregnant and her decision affects the life of an unborn fetus,[43] when a patient is the parent of small children who will become a burden to the state,[44] when a patient is a prisoner,[45] and some cases involving Jehovah's Witnesses.[46]

Complications arise when health professionals are forced to obtain an informed consent from an adult who appears to lack the mental capacity to make an informed choice regarding the proposed treatment. As previously mentioned, adult patients have the right to consent to treatment or to refuse it. If a patient is mentally incompetent he cannot consent to treatment and the informed consent will be deemed invalid. Reaching a conclusion of mental incompetence is difficult and of the utmost importance to the practitioner and the patient. Society promotes individualism and self-determinism, but incompetents

must be protected from poor decision-making when their health is involved.

Patients are incompetent if they are unconscious, severely retarded or highly intoxicated. If a patient cannot make decisions about his life, then he is incompetent. Moreover, any patient is legally competent unless there is a judicial order stating the contrary. The placement of a mentally retarded individual into a nursing home or a mental facility does not remove his right to consent to treatment.

Courts hesitate when they are faced with removing an individual's right to consent to medical treatment. If a patient understands the proposed treatment, the benefits, the alternatives and the consequences of refusing treatment, the courts will usually find that patient competent to provide consent.[47] In most circumstances, the courts are not affected by the irrational reasons for the decisions made by the patient in question or by possible questions as to whether the decision was one that a reasonable person would make. In summary, a patient will usually be found incompetent if he does not understand the consequences of his decision.

When patients are determined to be legally incompetent by a court, informed consent must be obtained from a legal guardian. The legal guardian is appointed by a court and may be a family member or proxy. If no legal guardian has

been appointed by the court, the health professional must obtain consent from the court. When faced with an informed consent issue, the courts will apply either the "best interest" standard or the "substituted judgment" rule. The "best interest" standard represents a decision that is in the best interest of the incompetent patient, and the "substituted judgment" rule represents a decision that the incompetent patient would make if he were competent. In either case, the final court decision is usually in the best interest of the patient.[30]

If a health professional feels that a court appointed guardian is not acting in the best interest of the incompetent patient and there is potential for harm, then the practitioner should intervene and, if necessary, petition the court to appoint a new legal guardian.

Health professionals are required by law to obtain an informed consent from a minor's parent or legal guardian standing in loco parentis.[48] Minors cannot consent to treatment because they cannot enter into legally binding contracts with health care providers, and because they are considered incapable of exercising sufficient judgment.[49] Parents have an obligation to care for and make decisions regarding the health of their minor children. This responsibility continues until the minor child reaches the age of majority, when the patient can consent to his own treatment. The age of majority is 18 years in all of the 50

states, except Nebraska, Missouri and Wyoming (19 years), Kentucky and Mississippi (21 years), and Alabama (14 years).

Failure to obtain informed consent from a parent or legal guardian has resulted in health professionals being sued for unauthorized treatment and battery. Physicians have been successfully sued for battery for performing treatment on minors after obtaining consent from adults who were not their parents or legal guardians; the physicians failed to obtain informed consent from the parent and therefore were not authorized to complete treatment.[50,51]

The common law has been modified by case law and legislation to provide for exceptions to consent when treating minors. The exceptions, which are not valid in every state, include emergency treatment, "mature minors," "emancipated minors," abused minors and other special cases, and objecting minors. In addition, there are limitations on parental consent when a parent fails to act in the best interest of the child. The Supreme Court of Massachusetts[52] stated:

> Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.

Parental consent may not be necessary if a true emergency exists and prompt treatment is necessary in order to

save the life of a minor or to prevent serious morbidity. In cases that were clearly medical emergencies, implied consent is considered acceptable consent. The law assumes that if the parent had been aware of the need for the medical treatment, they would have consented to treatment, as in Sullivan v. Montgomery.[53] If there is a legal challenge to the medical emergency exception, the health professional will be responsible to prove that a true medical emergency existed.[54]

New York state has a medical emergency provision in the statutes which states: "Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment, an emergency exists."[55]

Mature minors, in some circumstances, can give an informed consent for treatment.[56,57] The determination of which child is a mature minor must be determined on a case-by-case basis. Mature minors are close to the age of majority and demonstrate maturity. They have the ability to understand the proposed treatment, risks, benefits and alternatives. They have the intellect to provide a valid informed consent. The mature minor exception usually applies when a parent is not available and it would be best not to postpone medical or dental treatment. The mature minor exception will usually be affirmed by a court, but

as the risk of the procedure increases, it is best to obtain parental consent.

Minor children assume the legal responsibilites of an adult when they become "emancipated" in the eyes of the law. Usually, minors can become emancipated when they are living on their own,[58] self-supporting,[59] married,[60] pregnant, or in the armed forces.[61] Emancipated minors are acting as adults and may give consent for medical treatment.[62] Under most circumstances, it is inappropriate to obtain consent from an emancipated minor's parent.

Parental consent for a medical examination is not required in some states if a physician or a dentist suspects child abuse. Statute law in Texas[63] allows a physician or dentist to examine a child without parental consent if it appears that the child has been abused or neglected.

Many states authorize minors to consent to medical treatment when it relates to pregnancy,[64] drug or alcohol abuse,[64] mental health treatment,[65] contraception,[66] and abortion.[67]

Problems can develop when minors object to a proposed treatment that was consented to by the minor's parent or legal guardian. It is important for the health professional to realize that a number of courts place great emphasis on a child's wishes. It is probably best to obtain a valid

informed consent from the minor's parents and from the minor in such circumstances. Whether elected treatment can be forced upon a mature minor by his parents, as can life-saving procedures has not been decided by the courts.

Development of the Doctrine of Informed Consent in Indiana

The legal doctrine of informed consent is part of the common law of Indiana and of the United States.[68] The court decisions of Schloendorff v. Society of New York Hospitals,[20] Hunter v. Burroughs,[69] Salgo v. LeLand Stanford Jr. University Board of Trustees,[23] Natanson v. Kline,[24] and Miller v. Griesel[70] have influenced the Indiana legislature and judiciary in the development of informed consent in Indiana.

The first time an informed consent case came before the bar in an Indiana Court was the 1974 case of Joy v. Chau.[71] The Indiana Appellate Court (1st District) stated that a physician: "[is] negligent if he fail[s] to advise the [patient] of his injuries, methods of treatment, expected results or alternatives available."[71] The court described for the first time the standard for disclosure in Indiana: "[t]he physician has a duty to make a reasonable disclosure of material facts relevant to the decision which the patient is required to make."[71]

In 1980 the Indiana Appelate Court (4th District) provided an opinion in the Revord v. Russell case[72] which

addressed the limitations and definitions of a physician's broad duty of reasonable disclosure of material information.[68] The court found no need to disclose items likely to be known by the average patient or known by particular patients because of past experiences or conditions. The court further ruled that expert testimony must establish the risks requiring disclosure, and that a physician cannot and need not disclose risks of which he is unaware.[68] If the risks are found within the relevant literature, then the physician will be held to the "should have known standard."[68] The opinion of the court closely follows Natanson v. Kline[24] and the Professional Practice Standard.

The cases of Searcy v. Manganhas[73] and Kranda v. House-Norborg Medical Corporation[74] have been since upheld by the Indiana Appellate Courts. The decisions were based upon previous Indiana case law.[71,72] To date, the Indiana Supreme Court has not had occasion to provide an opinion on the doctrine of informed consent.

Indiana Health Care Consent Law

Indiana legislature amended Indiana Code (I.C.) 16-8-12, the Health Care Consent Law, in 1987 by the addition of Public Law 205-1987, Section 1, which provides for greater definition, scope and procedures for obtaining and giving consent to medical care.[68] The Health Care

Consent Law, I.C. 16-8-12-1 et seq. and I.C. 16-9.5-1-4 can be found in Appendix 1.

Previous Surveys

No previous studies have attempted to compare the viewpoints of the pediatric dentist and the trial attorney with regard to specific treatment and the need for informed consent. Therefore, a brief review will follow covering pertinent reports on the general subject of informed consent studies.

A few studies have dealt with informed consent with regard to disclosure practices and patient reaction. Hershey and Bushkoff[75] published a monograph entitled Informed Consent Study in 1969. They received responses from 10 physicians representing a total of 256 patient encounters. The authors stated:

> The study team feels there is evidence for the assumption that a fairly consistent standard for disclosure already exists to which most surgeons adhere to a greater extent than they either realize or admit...that adequate disclosure is feasible because these figures indicate that, for the majority of patients, the disclosure process, can be completed in less than 10 minutes although the pattern varies slightly from surgeon to surgeon.

Since the study's sample of the population was under-represented and did not represent a valid cross-section, the authors admit that the study offered little scientific proof of anything.

Hagman[76] conducted a study in 1970 and concluded that the required disclosures are medically and ethically sound, and are also legally acceptable.

Robinson and Merav[77] in 1976 investigated the ability of patients to recall preoperative treatment information. The authors tape recorded disclosure conversations of 200 patients. Four to six months later the patients were questioned regarding their recollection of the disclosure conversations. The authors reported that the patients were able to remember 29 percent of the preoperative information, but this percentage increased to 42 percent after the patients were reminded of details of the conversation. Robinson and Merav[77] advised that disclosure conversations be carefully documented at the time of the disclosure, to relieve the physician and the patient from relying solely on memory.

Alfidi[78] in 1971 investigated the reactions of 232 patients when they were asked to sign a consent form that disclosed an explicit description of the material risks associated with angiography. Approximately two percent of the patients refused to have the angiogram. He concluded:

> ...(2) We believe that a straightforward statement of complications will result in only a small percentage of patients refusing a special procedure. (3) We are convinced that the vast majority of patients desired this information... (5) We believe that we have proven that the majority of patients not only have a right to know, but want to know what possible complications may be expected from any given procedure. The concern that informing a patient of possible complications will result in his refusal of the procedure is now outmoded.

In 1975 Alfidi[79] conducted a second study which dealt with the disclosure of risks. He provided patients with a consent form which indicated that the proposed procedure had "significant hazards associated with it." A special block was provided on the consent form to allow the patient to alert the practitioner that more information was needed about possible risks. He found that two-thirds of the patients did not wish to be informed of additional risks.

Rosenberg[80] continued to investigate the work of Alfidi's[78] 1971 study. He asked 100 patients, hypothetically, if they would refuse to consent to a cerebral arteriogram if a number of risks were disclosed. Three-fourths of the patients said they would require disclosure of risks in order for them to make an intelligent decision. Of more importance in the study, Rosenberg[80] discovered that 50 percent of the patients would have refused consent due to the risks and potential complications of the proposed treatment.

Rosoff[81] conducted a large-scale informed consent study which distributed 3,362 questionnaires, each containing 39 questions. The response rate was 24 percent (810 questionnaires). The author concluded that the study did not prove anything, but that the

information should be applied to more practical applications. He stated:

> It is hoped that, consistant with original intentions, the information gathered through this study can be used to help the law of informed consent develop along more rational lines. Legal requirements that are adopted without regard for the practical problems of health care practitioners will not be met with favor; perhaps they will not be met at all. Even worse, ill-conceived laws can actually be counterproductive in terms of the attitudes and actions that the lawmakers wish to encourage. By providing researchers, the courts and legislatures with greater knowledge of the informed consent process, the present study may prevent some of the mistakes that might otherwise be made. The informed consent study had this as its main purpose: to open the eyes of the law as to what the physician-patient relationship entails and to open the ears of the medical profession as to what the law requires. Practical applications, more humane treatment and a safer legal environment in which physicians can function should follow. In a system that cares about human values, staffed with professionals who are well-intentioned, knowledge and understanding are the most important keys to improvement.

Schroeder[82] surveyed 1,000 practicing dentists throughout the United States. The response rate was 27 percent. The questionnaire dealt with dental jurisprudence. The author found that most of the respondents were interested in all phases of the law, with more than 50 percent of them showing a special interest in informed consent. It was recommended that the dental professional become aware at how their dental practices relate to the legal demands of American society. In addition to the dentist and the dental auxiliaries, the practice of dentistry is affected by patients, attorneys, government

bureaucrats, insurance company representatives, labor union officials and lay citizens.

Questionnaire

Mailed questionnaires have both advantages and disadvantages. Several advantages of a mailed questionnaire have been mentioned by Miller[83] (Appendix 2).

Kerlinger,[84] Parten[85] and Wallace[86] have evaluated the major disadvantages of a mailed questionnaire. Kerlinger[84] wrote that the lack of response and the inability to quantify the validity of the results were two serious drawbacks of a mailed questionnaire. The lack of response can question the validity of a mailed questionnaire. Kerlinger[84] and Wallace[86] agreed that the data obtained from respondents may differ from the data that would be obtained from non-respondents. If this were the case, then the sample would be biased and invalid. Allen[87] stated that with a large number of nonrespondents, the problem of respondent bias must be addressed: that is, did the persons who responded represent the total population to which the letters were sent? Or has some bias been introduced into the study by the nature and characteristics of those that responded?

Kerlinger[84] advised that a response rate of at least 80 percent is necessary to survey the entire cross section of the population. Wallace[86] stated that the unskilled

researcher usually has a difficult time obtaining valid data because the response rate ranges from 10 to 25 percent. Parten[85] felt that valid generalizations cannot be made when respondent response rates are low.

Additional disadvantages of a mailed questionnaire, as stated by Wickcliffe,[88] include the fact that validity depends on the ability and willingness of the respondent to provide information, the possibility that questions may be misinterpreted by the respondent, and the fact there is no way to identify any reluctance or evasiveness on the part of the respondent.

The form of the questionnaire must be clear, easy to understand and simple. Norusis[89] provided tips on designing a survey questionnaire (Appendix 3). Allen[87] stated that the proper design of questionnaires for scholarly research is a difficult and complex procedure, but the reliability of data is more a function of proper planning than of the technique used to collect those data. Allen[87] and Miller[83] provided a number of useful guidelines for constructing an effective questionnaire (Appendix 4, Appendix 5, respectively).

The foundation for a successful and valid accumulation of data from a mailed questionnaire requires a high respondent response rate. Miller[83] and Norton[90] have recommended several techniques that tend to yield a high respondent response rate. Norton found that the sponsor

of the questionnaire is important and could increase the returns by 17 percent. Wickcliffe[88] stated that professionals are more likely to return questionnaires than non-professionals. In addition, the respondent response rate of colleagues in a similar field is usually very good. Koroluk[91] surveyed his pediatric dental colleagues and had a response rate of 93 percent. The study of Sewell and Shaw, as cited by Miller,[83] found that the length of a questionnaire is critical; the shorter the questionnaire, the better the percentage returned. A technique advocated by Miller[83] results in a near doubling of the respondent response rate when stamps are placed on the enclosed return envelopes instead of metered postage. Allen[87] stated that there is no generally acceptable return rate, but one should expect to receive at least 30 percent to 40 percent of the questionnaires. He recommended a few special techniques to increase the return rate (Appendix 6).

METHODS AND MATERIALS

The data used in this cross-sectional study were collected from practicing pediatric dentists and trial attorneys in the state of Indiana by means of mailed questionnaires.

Each pediatric dentist and trial attorney received an introductory letter, a questionnaire and a self-addressed and stamped envelope (Appendixes 7-10).

The questionnaires were mailed to 85 pediatric dentists, comprising the entire available population of pediatric dentists in Indiana, on January 15, 1988, with a return date of January 29, 1988. The name and address of each pediatric dentist were obtained from the 1987 Pediatric Dentist Referral List.[92]

The Indiana State Bar Association[93] advised that the trial attorney would be the most familiar with dental malpractice and the doctrine of informed consent. Of the 8,309 attorneys reported to be practicing in Indiana, 731 are trial attorneys (Appendix 11).

A typical survey response rate for respondent attorneys in Indiana, as computed by the Indiana State Bar Association, has been in the range of 30 to 40 percent.

There are 11 districts within the Indiana State Bar Association (Appendix 12). In order to obtain a represen-

tative sample of trial attorneys in each of the 11 districts, without allowing large populated districts to be over-represented and small populated districts to be under-represented, a stratified sample of trial attorneys in each of the 11 districts was obtained. The trial attorneys were selected according to population of the communities in which they practice. Community population was determined by census figures[94] and each practice location was placed into one of four categories:

1. less than 5,000;
2. 5,000 to 25,000;
3. 25,000 to 100,000; and
4. greater than 100,000.

Therefore, the group that received questionnaires was considered representative of the trial attorney population in Indiana.

The survey questionnaires were mailed to 350 trial attorneys distributed in each of the 11 Indiana State Bar Association districts. The name and address of each trial attorney were obtained from the Indiana State Bar Association. Peel-type mailing labels were purchased from the Indiana State Bar Association and attached to each envelope. The questionnaires were mailed on February 3, 1988 with a return date of February 12, 1988.

Questionnaire

A questionnaire was designed using the recommendations of Miller,[83] Allen,[87] Norusis,[89] and Norton.[90]

The questionnaire was three pages long, incorporated 16 questions and instructed the respondent to answer each question with a check mark. The questionnaire was pretested and ambiguous questions clarified. The pretest revealed that seven to 10 minutes were required to complete the questionnaire.

Question one surveyed the respondent's age. Question two evaluated the respondent's community population where his/her practice is located.

Question three obtained information with regard to the respondent's year of graduation from professional school, any postgraduate studies and the type of qualifications obtained (certificate or Master's degree with certificate).

Question four investigated how familiar the pediatric dentist and the trial attorney are with the doctrine of informed consent.

Question five attempted to have the respondent speculate on whether the average pediatric dentist conforms to the doctrine of informed consent.

Question six evaluated how pediatric dentists obtain informed consent and how trial attorneys recommend that the pediatric dentist obtain consent for treatment. The respondent was given three choices: oral only, oral and verified

in dental record, and oral and the use of an informed consent form.

Question seven investigated the opinions of the pediatric dentist and the trial attorney by asking if the duty to obtain an informed consent is necessary in the practice of pediatric dentistry.

Questions eight and nine evaluated the views of the pediatric dentists and trial attorneys on how well the pediatric dentists' dental school education and specialty training adequately prepared them to obtain informed consent. The possible answers were strongly agree, agree, disagree and strongly disagree.

To evaluate a possible tendency for increased education with informed consent, question 10 served to evaluate courses taken by pediatric dentists and trial attorneys.

Question 11 investigated the opinions of pediatric dentists and trial attorneys on whether the pediatric dentist is more concerned with obtaining informed consent today than they were in the past.

Question 12 attempted to evaluate the time spent on obtaining informed consent in the pediatric dental office over the past few years.

Question 13 asked the pediatric dentists and trial attorneys to estimate the amount of time spent by the pediatric dentist obtaining informed consent on each patient. The respondents were given the following options:

none, less than 5 minutes, 6-10 minutes, 11-15 minutes, 16-20 minutes and greater than 20 minutes.

The pediatric dentists and trial attorneys were asked to recommend which patients would require parental consent before providing any dental treatment (question 14). The respondents were given the option of choosing any minor, a mature minor (14-18 years), an emancipated minor, an incompetent minor, a pregnant minor, a married minor, a minor presenting as an emergency, a minor with no parent or guardian, a runaway minor, a 21-year-old severely mentally retarded patient and/or a one-year-old infant of a 14-year-old mother. The respondents were given the option of choosing all answers that might apply.

Question 15 was constructed to evaluate the pediatric dentists' and trial attorneys' recommendations on consent for 37 different clinical procedures. The respondents were asked to check the type of consent (that is, implied consent, oral informed consent and/or written informed consent) that they would recommend before the start of each procedure. The dental procedures ranged from a dental examination to treatment under general anesthesia.

Question 16 inquired whether the responding pediatric dentists and trial attorneys felt that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation.

A short space was provided at the end of the questionnaire (question 17) for any additional comments.

The questionnaire for trial attorneys contained the same survey content as the questionnaire for pediatric dentists, except that procedure terminology was slightly different. As an example, the questionnaire for pediatric dentists included I.M. sedation while the questionnaire for trial attorneys included injection of drugs into muscle. The difference in terminology was for clarity and did not appear to influence the interpretation of the questionnaire by the trial attorney.

The questionnaires were accompanied with cover letters. The questionnaire was professionally typed and then photocopied. Each cover letter was individually typed and personalized with name, address and salutation on Indiana University School of Dentistry or Indiana University School of Law stationery. The cover letter identified the investigators, explained the purpose of the research, gave directions and provided a telephone number to answer any questions the respondent might have regarding the study. Each cover letter was signed by the principal investigator.

The collected data were evaluated using the Statistical Analysis System (SAS) with chi-square analyses.

RESULTS

A total of 435 questionnaires were mailed to Indiana pediatric dentists and trial attorneys. Of the 435 questionnaires, 85 were mailed to pediatric dentists and 350 to trial attorneys.

The response rate for pediatric dentists was 70.6 percent and the response rate for trial attorneys was 61.4 percent.

The results are summarized in Tables I-XX. A number of pediatric dentists and trial attorneys failed to share their opinion on some questions or lacked an opinion. To improve the validity of this study, instances of unanswered questions were not included in percentage calculations.

Table I displays the distribution of trial attorneys in Indiana. Approximately 65 percent of trial attorneys are evenly distributed throughout the state and the remaining 35 percent are in the Indianapolis area.

Table II reveals the age distribution of responding pediatric dentists and trial attorneys. The data indicate that the majority of respondents were between 30 and 49 years of age (pediatric dentists: 69.5 percent; trial attorneys: 69.1 percent). The age distribution between the two groups is similar.

Table III shows the percent distribution of pediatric dentists and trial attorneys by community population size. The distribution of respondents in communities with more than 100,000 population was similar. Approximately twice as many pediatric dentists as trial attorneys who responded to the survey were located in communities with populations of 25,000-100,000. There were no responding pediatric dentists practicing in communities of less than 5,000.

The distribution of pediatric dentists and trial attorneys with respect to year of graduation from professional school is summarized in Table IV. The distribution is similar between the two populations and each age group is equally represented in this study.

Table V shows the distribution of pediatric dentists with respect to year of completion of postgraduate specialty training. Seventy-seven percent of responding pediatric dentists graduated within the past 22 years.

Table VI reveals the specialty qualifications of responding pediatric dentists. A minority of the responding pediatric dentists (27.1 percent) had earned a certificate and a Master's degree, whereas 72.9 percent of responding pediatric dentists had achieved a certificate only.

The majority of the respondents were moderately familiar with the doctrine of informed consent (pediatric dentists: 64.2 percent; trial attorneys: 56.7 percent) as tabulated in Table VII.

As Table VIII shows, 57.9 percent of the responding pediatric dentists feel that the average pediatric dentist conforms to the doctrine of informed consent. In contrast, 60.9 percent of the trial attorneys feel that the average pediatric dentist does not conform to the doctrine.

The perceptions of pediatric dentists and trial attorneys on how pediatric dentists obtain consent for treatment are summarized in Table IX. The majority of the pediatric dentists and trial attorneys indicated that the pediatric dentist does not obtain consent for treatment either by oral communication only or by oral communication that is verified in the dental record. However, the majority of trial attorneys feel that the pediatric dentist obtains consent for treatment orally and with the use of an informed consent form. The pediatric dentists were divided on this question.

Table X represents the perceptions of pediatric dentists and trial attorneys on whether the duty to obtain an informed consent is necessary in the practice of pediatric dentistry. Approximately 91.5 percent of pediatric dentists and 97.0 percent of trial attorneys agreed that the duty to obtain an informed consent is necessary in the practice of pediatric dentistry.

Table XI summarizes opinions on whether the pediatric dentists' dental school education and specialty training adequately prepared them to obtain an informed consent.

The distribution of continuing education courses taken by pediatric dentists and trial attorneys which dealt with the doctrine of informed consent is summarized in Table XII. Approximately 28.8 percent of pediatric dentists and 28.8 percent of trial attorneys had taken continuing education courses which dealt with informed consent. In 1987, 50.0 percent of pediatric dentists and 33.3 percent of trial attorneys had taken a course that dealt with informed consent.

Table XIII reveals that the majority of pediatric dentists and trial attorneys think that pediatric dentists are more concerned with obtaining informed consent today than they were in the past (pediatric dentists: 83.1 percent; trial attorneys: 96.7 percent).

Table XIV shows that 81.5 percent of trial attorneys and 44.1 percent of pediatric dentists think pediatric dentists spend more time obtaining informed consent than in the past. Fifty-five percent of pediatric dentists felt that the time spent obtaining informed consent has remained the same (trial attorneys: 17.1 percent).

The majority of pediatric dentists (66.1 percent) and trial attorneys (74.5 percent) estimate that less than five minutes is spent obtaining informed consent.

The perceptions of pediatric dentists and trial attorneys on which type of patient requires parental consent is summarized in Table XVI.

The type of consent selected by pediatric dentists and trial attorneys for specific dental procedures is tabulated in Table XVI. The type varied depending upon the procedure. The majority of the pediatric dentists (43.9 percent) and trial attorneys (74.2 percent) indicated that implied consent is adequate for a dental examination. However, 90.9 percent of pediatric dentists and 92.5 percent of trial attorneys recommended obtaining written informed consent for general anesthesia.

A large number of additional comments were written by pediatric dentists and trial attorneys and they are located in Appendixes 13 and 14.

The majority of the pediatric dentists (63.8 percent) and trial attorneys (85.1 percent) agreed that conforming with the doctrine of informed consent would reduce or eliminate future malpractice litigation.

The data compiled in Tables I-XVIII were statistically analyzed using the Statistical Analysis System (SAS). Chi-square analyses were performed to evaluate the possible differences that age and population would have upon the respondent's answers to the questionnaire. The chi-square analyses revealed no significant differences.

TABLES

TABLE I

Distribution of trial attorneys in Indiana

Bar District	% of Indiana Trial Attorneys	Number Surveyed
District 1	8	28
District 2	6	21
District 3	8	28
District 4	8	28
District 5	7	24
District 6	7	24
District 7	6	21
District 8	6	21
District 9	5	18
District 10	4	14
District 11	35	123
Total	100	350

TABLE II

Age distribution of responding pediatric dentists and trial attorneys

Age	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	5	-
< 30	3	5.1	10	4.8
30-39	20	33.9	72	34.3
40-49	21	35.6	73	34.8
50-59	9	15.3	28	13.3
>59	6	10.2	27	12.9
Total	60	100.0	215	100.0

TABLE III

Community practice population and percent distribution of pediatric dentists and trial attorneys

Community Practice Population	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	2	-	5	-
> 100,000	31	53.4	126	60.0
25,000-100,000	22	37.9	42	20.0
5,000-25,000	5	8.6	37	17.6
< 5,000	-	-	5	2.4
Total	60	100.0	215	100.0

TABLE IV

Distribution of pediatric dentists and trial attorneys with respect to year of graduation from professional school

Completion Of Professional School	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	5	-
Prior to 1965	19	32.2	68	32.4
1966-1975	20	33.9	63	30.0
1976-1987	20	33.9	79	37.6
Total	60	100.0	215	100.0

TABLE V

Distribution of pediatric dentists with respect to year of completion of postgraduate specialty training

Completion Of Specialty Training	Pediatric Dentist Number	Percent
No opinion	2	-
Prior to 1965	13	22.4
1966-1975	21	36.2
1976-1987	24	41.4
Total	60	100.0

TABLE VI

Specialty qualifications of responding pediatric dentists

Specialty Qualifications	Pediatric Dentist Number	Percent
No opinion	1	-
Certificate	43	72.9
Master's degree and certificate	16	27.1
Total	60	100.0

TABLE VII

Perceptions of pediatric dentists and trial attorneys with respect to their familiarity with the doctrine of informed consent

Familiarity	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	6	-
Extremely familiar	7	11.9	61	29.1
Moderately familiar	38	64.2	119	56.7
Vaguely familiar	13	22.0	26	12.4
Unfamiliar	1	1.7	4	1.9
Total	60	100.0	215	100.0

TABLE VIII

Perceptions of pediatric dentists and trial attorneys on whether the average pediatric dentist conforms to the doctrine of informed consent

Conforms	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	77	-
Yes	33	57.9	54	39.1
No	24	42.1	84	60.9
Total	60	100.0	215	100.0

TABLE IX

Perceptions of pediatric dentists and trial attorneys on how pediatric dentists should obtain consent for treatment

Oral Only	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	21	35.0	10	4.7
No	39	65.1	205	95.3
Total	60	100.0	215	100.0

Oral And Verified In Dental Record	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	21	35.0	52	24.2
No	39	65.1	163	75.8
Total	60	100.0	215	100.0

TABLE IX (Continued)

Oral And Use Of An Informed Consent Form	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	29	48.3	165	76.7
No	31	51.7	50	23.3
Total	60	100.0	215	100.0

TABLE X

Perceptions of pediatric dentists and trial attorneys on whether the duty to obtain informed consent is necessary in the practice of pediatric dentistry

Necessary To Obtain Informed Consent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	12	-
Yes	54	91.5	197	97.0
No	5	8.5	6	3.0
Total	60	100.0	215	100.0

TABLE XI

Perceptions of pediatric dentists and trial attorneys on whether the pediatric dentists' dental school education and specialty training adequately prepared them to obtain an informed consent

Dental School Education	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	136	-
Strongly agree	1	1.7	2	2.5
Agree	20	33.9	33	41.8
Disagree	26	44.1	41	51.9
Strongly disagree	12	20.3	3	3.8
Total	60	100.0	215	100.0

Specialty Training	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	2	-	139	-
Strongly agree	11	19.0	2	2.6
Agree	27	46.6	41	53.9
Disagree	16	27.6	32	42.1
Strongly disagree	4	6.9	1	1.3
Total	60	100.0	215	100.0

TABLE XII

Distribution of continuing education courses taken by pediatric dentists and trial attorneys which dealt with the doctrine of informed consent

Continuing Education Courses Taken On Informed Consent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	10	-
Yes	17	28.8	59	28.8
No	42	71.2	146	71.2
Total	60	100.0	215	100.0

Continuing Education Courses Taken On Informed Consent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
None	44	-	174	-
Prior to 1983	3	18.9	9	21.5
1983	1	6.3	0	0.0
1984	2	12.5	6	14.3
1985	1	6.3	5	11.9
1986	0	0.0	6	14.3
1987	8	50.0	14	33.3
1988	1	6.3	2	4.8
Total	60	100.0	215	100.0

TABLE XIII

Perceptions of pediatric dentists and trial attorneys on whether pediatric dentists are more concerned with obtaining informed consent today than they were in the past

More Concerned With Obtaining Informed Consent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	63	-
Yes	49	83.1	147	96.7
No	10	16.9	5	3.3
Total	60	100.0	215	100.0

TABLE XIV

Perceptions of pediatric dentists and trial attorneys on whether pediatric dentists spend more or less time obtaining informed consent

Time Spent Obtaining Informed Consent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	69	-
Decreased	0	0.0	2	1.4
Remained the same	33	55.9	25	17.1
Increased	26	44.1	119	81.5
Total	60	100.0	215	100.0

TABLE XV

Perceptions of pediatric dentists and trial attorneys on how much time is spent obtaining informed consent

Time Spent	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	1	-	54	-
None	2	3.4	6	3.7
< 5 minutes	39	66.1	120	74.5
6-10 minutes	12	20.3	29	18.1
11-15 minutes	4	6.8	4	2.5
16-20 minutes	0	0.0	0	0.0
> 20 minutes	2	3.4	2	1.2
Total	60	100.0	215	100.0

TABLE XVI

Perceptions of pediatric dentists and trial attorneys on which type of patient requires parental consent

Any Minor	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	58	96.7	160	74.4
No	2	3.3	55	25.6
Total	60	100.0	215	100.0

A Mature Minor	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	48	80.0	116	54.0
No	12	20.0	99	46.0
Total	60	100.0	215	100.0

An Emancipated Minor	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	39	65.0	40	18.6
No	21	35.0	175	81.4
Total	60	100.0	215	100.0

TABLE XVI (Continued)

An Incompetent Minor	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	50	83.3	139	64.7
No	10	16.7	76	35.3
Total	60	100.0	215	100.0

A Pregnant Minor	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	48	80.0	117	54.4
No	12	20.0	98	45.6
Total	60	100.0	215	100.0

A Married Minor	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	37	61.7	33	15.3
No	23	38.3	182	84.7
Total	60	100.0	215	100.0

TABLE XVI (Continued)

A Minor Presenting As An Emergency	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	45	75.0	64	29.8
No	15	25.0	151	70.2
Total	60	100.0	215	100.0

A Minor With No Parent Or Guardian	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	38	63.3	53	24.7
No	22	36.7	162	75.3
Total	60	100.0	215	100.0

A Runaway Minor	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
Yes	39	65.0	68	31.6
No	21	35.0	147	68.4
Total	60	100.0	215	100.0

TABLE XVI (Continued)

A 21-Year-Old Mentally Retarded Patient	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	51	85.0	139	64.7
No	9	15.0	76	35.3
Total	60	100.0	215	100.0

A One-Year-Old Infant Of A 14-Year-Old Mother	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
Yes	48	80.0	127	59.1
No	12	20.0	88	40.9
Total	60	100.0	215	100.0

TABLE XVII

Type of consent selected by pediatric dentists and trial attorneys for specific dental procedures

Examination	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	33	-
Implied consent	25	43.9	135	74.2
Oral informed consent	18	31.6	23	12.6
Written informed consent	12	21.1	21	11.5
Implied and oral informed consent	0	0.0	1	0.5
Oral and written informed consent	2	3.5	2	1.1
Total	60	100.0	215	100.0

An Oral Examination For Research	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	6	-	32	-
Implied consent	1	1.9	14	7.7
Oral informed consent	13	24.1	49	26.8
Written informed consent	39	72.2	116	63.4
Oral and written informed consent	1	1.9	4	2.2
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Prophylaxis	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	33	-
Implied consent	13	22.8	115	63.2
Oral informed consent	29	50.9	39	21.4
Written informed consent	13	22.8	24	13.2
Implied and oral informed consent	0	0.0	2	1.1
Oral and written informed consent	2	3.5	2	1.1
Total	60	100.0	215	100.0

Topical Fluoride	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	35	-
Implied consent	12	21.1	57	31.7
Oral informed consent	30	52.6	79	43.9
Written informed consent	13	22.8	39	21.7
Implied and oral informed consent	0	0.0	2	1.1
Oral and written informed consent	2	3.5	3	1.7
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Radiographs	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	28	-
Implied consent	7	12.3	29	15.5
Oral informed consent	32	56.1	80	42.8
Written informed consent	14	24.6	70	37.4
Implied and oral informed consent	0	0.0	1	0.5
Oral and written informed consent	4	7.0	7	3.7
Total	60	100.0	215	100.0

Restorations	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	28	-
Implied consent	2	3.5	24	12.8
Oral informed consent	32	56.1	87	46.5
Written informed consent	18	31.6	72	38.5
Implied and oral informed consent	0	0.0	1	0.5
Oral and written informed consent	5	8.8	3	1.6
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Crowns	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	30	-
Implied consent	2	3.5	14	7.6
Oral informed consent	28	49.1	71	38.4
Written informed consent	20	35.1	97	52.4
Implied and oral informed consent	1	1.8	0	0.0
Oral and written informed consent	6	10.5	3	1.6
Total	60	100.0	215	100.0

A Photograph For Publication	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	2	-	29	-
Implied consent	0	0.0	2	1.1
Oral informed consent	7	12.1	14	7.5
Written informed consent	49	84.5	167	89.8
Oral and written informed consent	2	3.4	3	1.6
Total	60	100.0	215	100.0

TABLE XVII (Continued)

A Photograph For Group Presentations	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	2	-	29	-
Implied consent	0	0.0	2	1.1
Oral informed consent	8	13.8	11	5.9
Written informed consent	47	81.0	169	90.9
Oral and written informed consent	3	5.2	4	2.2
Total	60	100.0	215	100.0

An Experimental Procedure	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	4	-	28	-
Implied consent	0	0.0	1	0.5
Oral informed consent	0	0.0	7	3.7
Written informed consent	55	98.2	175	93.6
Oral and written informed consent	1	1.8	4	2.1
Total	60	00.0	215	100.0

TABLE XVII (Continued)

Extraction Of A Loose Primary Tooth	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	3	-	31	-
Implied consent	3	5.3	41	22.3
Oral informed consent	40	70.2	81	44.0
Written informed consent	9	15.8	59	32.1
Implied and oral informed consent	1	1.8	0	0.0
Oral and written informed consent	4	7.0	3	1.6
Total	60	100.0	215	100.0

Extraction Of An Infected Primary Tooth	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	3	-	28	-
Implied consent	0	0.0	24	12.8
Oral informed consent	39	68.4	60	32.1
Written informed consent	13	22.8	99	52.9
Oral and written informed consent	5	8.8	4	2.1
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Extraction Of A Permanent Tooth	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	3	-	25	-
Implied consent	0	0.0	3	1.6
Oral informed consent	34	59.6	52	27.4
Written informed consent	19	33.3	131	68.9
Oral and written informed consent	4	7.0	4	2.1
Total	60	100.0	215	100.0

Root Canal Treatment	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	3	-	28	-
Implied consent	0	0.0	1	0.5
Oral informed consent	40	70.2	38	20.3
Written informed consent	13	22.8	142	75.9
Implied and written informed consent	0	0.0	1	0.5
Oral and written informed consent	4	7.0	5	2.7
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Pulp Therapy For A Primary Tooth	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	33	-
Implied consent	0	0.0	3	1.6
Oral informed consent	40	70.2	38	20.9
Written informed consent	13	22.8	136	74.7
Oral and written informed consent	4	7.0	5	2.7
Total	60	100.0	215	100.0

Space Maintenance	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	36	-
Implied consent	1	1.8	11	6.1
Oral informed consent	39	68.4	72	40.2
Written informed consent	13	22.8	92	51.4
Oral and written informed consent	4	7.0	4	2.2
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Orthodontics	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	3	-	27	-
Implied consent	0	0.0	3	1.6
Oral informed consent	8	14.0	27	14.4
Written informed consent	44	77.2	153	81.4
Oral and written informed consent	5	8.8	5	2.7
Total	60	100.0	215	100.0

Oral Surgery	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	24	-
Implied consent	0	0.0	1	0.5
Oral informed consent	26	46.4	12	6.3
Written informed consent	26	46.4	174	91.1
Implied and oral informed consent	1	1.8	0	0.0
Oral and written informed consent	3	5.4	4	2.1
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Over-The-Counter Drugs	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	32	-
Implied consent	10	17.9	45	24.6
Oral informed consent	38	67.9	80	43.7
Written informed consent	7	12.5	54	29.5
Oral and written informed consent	1	1.8	4	2.2
Total	60	100.0	215	100.0

Prescription For Controlled Drugs	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	30	-
Implied consent	2	3.6	5	2.7
Oral informed consent	27	48.2	66	35.7
Written informed consent	23	41.1	110	59.5
Oral and written informed consent	4	7.1	4	2.2
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Use Of Local Anesthesia	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	3	-	29	-
Implied consent	7	12.3	6	3.2
Oral informed consent	33	57.9	82	44.1
Written informed consent	14	24.6	95	51.1
Oral and written informed consent	3	5.3	3	1.6
Total	60	100.0	215	100.0

Use Of Dangerous Drugs Or Chemicals	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	7	-	26	-
Implied consent	2	3.8	1	0.5
Oral informed consent	5	9.4	14	7.4
Written informed consent	43	81.1	170	89.9
Implied, oral and written informed consent	1	1.9	0	0.0
Oral and written informed consent	2	3.8	4	2.1
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Periodontal Surgery	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	5	-	27	-
Implied consent	0	0.0	1	0.5
Oral informed consent	26	47.3	11	5.9
Written informed consent	27	49.1	171	91.0
Oral and written informed consent	2	3.6	5	2.7
Total	60	100.0	215	100.0

Oral Sedation	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	29	-
Implied consent	0	0.0	1	0.5
Oral informed consent	22	39.3	53	28.5
Written informed consent	31	55.4	127	68.3
Oral and written informed consent	3	5.4	5	2.7
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Nitrous Oxide	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	30	-
Implied consent	3	5.4	2	1.1
Oral informed consent	32	57.1	49	26.5
Written informed consent	18	32.1	131	70.8
Oral and written informed consent	3	5.4	3	1.6
Total	60	100.0	215	100.0

I.M. Sedation	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	7	-	28	-
Implied consent	0	0.0	1	0.5
Oral informed consent	9	17.0	49	26.2
Written informed consent	43	81.1	133	71.1
Oral and written informed consent	1	1.9	4	2.1
Total	60	100.0	215	100.0

TABLE XVII (Continued)

I.V. Sedation	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	7	-	28	-
Implied consent	0	0.0	1	0.5
Oral informed consent	6	11.3	39	20.9
Written informed consent	46	86.8	143	76.5
Oral and written informed consent	1	1.9	4	2.1
Total	60	100.0	215	100.0

General Anesthesia	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	5	-	28	-
Implied consent	0	0.0	1	0.5
Oral informed consent	4	7.3	9	4.8
Written informed consent	50	90.9	173	92.5
Oral and written informed consent	1	1.8	4	2.1
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Expanded Function Dental Assistants	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	5	-	34	-
Implied consent	26	47.3	18	9.9
Oral informed consent	20	36.4	68	37.6
Written informed consent	8	14.5	91	50.3
Oral and written informed consent	1	1.8	4	2.2
Total	60	100.0	215	100.0

Use Of Restraints	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	5	-	40	-
Implied consent	7	12.7	9	5.1
Oral informed consent	26	47.3	53	30.3
Written informed consent	19	34.5	110	62.9
Oral and written informed consent	3	5.5	3	1.7
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Hand Over Mouth Exercise	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	5	-	86	-
Implied consent	9	16.4	18	14.0
Oral informed consent	25	45.5	56	43.4
Written informed consent	14	25.5	52	40.3
Implied and oral informed consent	3	5.5	0	0.0
Oral and written informed consent	4	7.3	3	2.3
Total	60	100.0	215	100.0

Hand Over Mouth Restricted Airway	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	14	-	87	-
Implied consent	7	15.2	13	10.2
Oral informed consent	20	43.5	46	35.9
Written informed consent	16	34.8	66	51.6
Implied and written informed consent	1	2.2	0	0.0
Oral and written informed consent	2	4.3	3	2.3
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Mouth Props	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	4	-	46	-
Implied consent	22	39.3	27	16.0
Oral informed consent	21	37.5	79	46.7
Written informed consent	10	17.9	58	34.3
Implied and oral informed consent	1	1.8	0	0.0
Oral and written informed consent	2	3.6	5	3.0
Total	60	100.0	215	100.0

Auxiliary Restraint	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	5	-	46	-
Implied consent	12	21.8	15	8.9
Oral informed consent	29	52.7	63	37.3
Written informed consent	11	20.0	86	50.9
Implied and oral informed consent	1	1.8	0	0.0
Oral and written informed consent	2	3.6	5	3.0
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Use Of Any Behavior Management Technique	Pediatric Dentist		Trial Attorney	
	Number	Percent	Number	Percent
No opinion	5	-	49	-
Implied consent	14	25.5	18	10.8
Oral informed consent	24	43.6	50	30.1
Written informed consent	12	21.8	94	56.6
Implied and oral informed consent	1	1.8	1	0.6
Oral and written informed consent	4	7.3	3	1.8
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Life-Threatening Emergencies	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	5	-	43	-
Implied consent	22	40.0	75	43.6
Oral informed consent	13	23.6	30	17.4
Written informed consent	19	34.5	59	34.3
Implied and oral informed consent	0	0.0	2	1.2
Implied and written informed consent	0	0.0	2	1.2
Implied, oral and written informed consent	0	0.0	1	0.6
Oral and written informed consent	1	1.8	3	1.7
Total	60	100.0	215	100.0

TABLE XVII (Continued)

Non-Life-Threatening Emergencies	Pediatric Dentist Number	Pediatric Dentist Percent	Trial Attorney Number	Trial Attorney Percent
No opinion	4	-	34	-
Implied consent	10	17.9	16	8.8
Oral informed consent	35	62.5	74	40.9
Written informed consent	8	14.3	81	44.8
Implied and oral informed consent	0	0.0	1	0.6
Implied and written informed consent	0	0.0	2	1.1
Implied, oral and written informed consent	1	1.8	1	0.6
Oral and written informed consent	2	3.6	6	3.3
Total	60	100.0	215	100.0

TABLE XVIII

Perceptions of pediatric dentists and trial attorneys on the importance of conformity by pediatric dentists to the doctrine of informed consent to reduce or eliminate future malpractice litigation

Reduces Malpractice Litigation	Pediatric Dentist Number	Percent	Trial Attorney Number	Percent
No opinion	2	-	13	-
Yes	37	63.8	172	85.1
No	21	36.2	30	14.9
Total	60	100.0	215	100.0

TABLE XIX

Type of consent agreed on by pediatric dentists and trial attorneys for specific dental procedures

Implied Consent	Oral Informed Consent
Oral examination	Over-the-counter drugs
Life-threatening emergencies	Hand over mouth exercise
	Topical fluoride
	Restorations
	Radiographs
	Extraction of a loose primary tooth

TABLE XIX (Continued)

Written Informed Consent
Orthodontics
Oral surgery
Use of any dangerous drug or chemical
Periodontal surgery
Oral sedation
I.M. sedation
I.V. sedation
General anesthesia
A photograph for publication
A photograph for group presentations
An experimental procedure
An oral examination for research

TABLE XX

Type of consent disagreed on by pediatric dentists and trial attorneys for specific dental procedures

Oral Informed Consent: Pediatric Dentists	Implied Consent: Trial Attorneys
Prophylaxis	
Implied Consent: Pediatric Dentists	Oral Informed Consent: Trial Attorneys
Use of mouth props	
Implied Consent: Pediatric Dentists	Written Informed Consent: Trial Attorneys
Expanded Function Dental Auxiliaries	

TABLE XX (Continued)

Oral Informed Consent: Pediatric Dentists	Written Informed Consent: Trial Attorneys
Crowns	
Extraction of an infected primary tooth	
Extraction of a permanent tooth	
Root canal treatment	
Pulp therapy on a primary tooth	
Space maintenance	
Prescription for controlled substances	
Local anesthesia in the office	
Use of restraining devices	
Use of hand over mouth restricted airway	
Use of auxiliary restraint	
Use of any behavior management technique	
Non-life-threatening emergencies	
Nitrous Oxide	

DISCUSSION

This study has provided some interesting insights into the practical application of the doctrine of informed consent to pediatric dentistry. The primary purpose of the study was to acquaint pediatric dentists and trial attorneys with the views of the other concerning the doctrine of informed consent, and in particular to raise the level of awareness of the doctrine among pediatric dentists. Additional goals were to gather information on how pediatric dentists obtain informed consent, on how trial attorneys recommend obtaining informed consent, and on changing trends in the pediatric dental office with regard to the doctrine of informed consent.

Overall, most pediatric dentists and trial attorneys were moderately familiar with the doctrine of informed consent. However, trial attorneys do not feel that pediatric dentists conform to the doctrine, while pediatric dentists perceive that they do conform. Pediatric dentists and trial attorneys recommend that informed consent be obtained orally and be documented on an informed consent form. Both professional groups agree that the duty to obtain an informed consent is necessary in the practice of pediatric dentistry. However, pediatric dentists and trial attorneys do not feel that either dental school education

or specialty training prepares the pediatric dentist to obtain an informed consent. Not surprisingly, both groups felt that pediatric dentists are more concerned with obtaining informed consent today than they were in the past. Most pediatric dentists are obtaining informed consent in less than five minutes. Pediatric dentists feel that the time spent obtaining informed consent has either remained the same (55.9 percent) or increased (44.1 percent); trial attorneys feel that the trend is toward increased time (81.5 percent). Overall, pediatric dentists and trial attorneys disagree on whether parental consent is required for specific patient types. Moreover, this study revealed that pediatric dentists and trial attorneys agree on the type of consent necessary for 20 dental procedures (54 percent) and disagree on 17 dental procedures (46 percent). Finally, most trial attorneys and pediatric dentists feel that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation.

The following discussion will explore these findings in greater detail. The response rate, methodology, demographics, trends, and the type of informed consent required for specific dental procedures will be emphasized. Finally, clinical implications and suggestions for future research will be addressed.

A total of 435 questionnaires were mailed to Indiana pediatric dentists and trial attorneys. Of the 435 questionnaires, 85 were mailed to pediatric dentists and 350 were mailed to trial attorneys. The response rate for pediatric dentists was 70.6 percent and for trial attorneys it was 61.4 percent. The response rate to this survey was greater than in past informed consent studies,[81,82] and is within an acceptable range for formulating valid conclusions. As noted earlier, Rosoff[81] distributed 3,362 questionnaires and had a response rate of 24 percent, and Schroeder[82] surveyed 1,000 dentists throughout the United States and had a response rate of 27 percent. The Indiana State Bar Association[93] reported past respondent rates of 30 to 40 percent. The response rate for trial attorneys in this study was much better than anticipated. A number of factors may have contributed to the success of this survey and the good response rate: Indiana pediatric dentists and trial attorneys appear to have an interest in the doctrine of informed consent, the questionnaire was constructed using the recommendations of Miller,[83] Allen[87] and Norusis,[89] the population surveyed was made up of two professional groups,[88] the cover letters were typed on Indiana University stationery from either the Department of Pediatric Dentistry or the Law School, and each pediatric dentist and trial attorney received in the mail a self-addressed and stamped envelope. In addition, the high

response rates may be due to the fact that each survey questionnaire was accompanied by a cover letter which was personalized with each potential respondent's name, and signed by the investigator. The design of the questionnaire and cover letter enabled the investigator to obtain data that seemed reliable, valid and usable. Thus, the methods used in this study were appropriate.

The information obtained from pediatric dentists appears to reliably indicate the knowledge base of pediatric dentists regarding the doctrine of informed consent. However, the knowledge base for trial attorneys appears to be less reliable. There are at least two reasons for this difference in reliability. First, the questionnaire included language most familiar to pediatric dentists. Second, most pediatric dentists answered every question while a greater number of trial attorneys failed to answer some questions. Most of the unanswered questions were answered with no opinion. However, a small number of questions were left blank. One can hypothesize that trial attorneys failed to answer a question because they either had no opinion, lacked enough knowledge to answer the question, or had an opinion but refused to share that opinion. Therefore, the respondents with no opinion were separated from the respondents with an opinion, and percent calculations were based on actual responses.

The survey showed that the majority of both professional groups are familiar with the doctrine, but their level of knowledge differs. One trial attorney, now a judge, commented, "I have not heard of the doctrine of informed consent and I am more inclined to think that this is a term used around law schools rather than out in the practice of law." In contrast, a trial attorney with more experience with the doctrine stated:

> I have defended several dentists in malpractice suits and informed consent has come up as an issue in extraction and root canal therapy cases. Dentists definitely need to be more aware of their duties in this area.

In addition to determining the amount of knowledge that both professional groups currently have with the doctrine of informed consent, the direction that future litigation will take is important. It is not reasonable to assume that all attorneys have to be aware of the doctrine as it relates to pediatric dentistry, only that a small sample of the trial attorneys are aware of the current status of this issue. Medical malpractice is a specialty of law and represents a small percentage of trial attorneys. This small group of litigators is responsible for the formation and the direction of the law. If a significant proportion of trial attorneys are aware of informed consent as it relates to dentistry, it can be predicted that this group, even if relatively small, will provide leadership to the rest of the bar in pursuing this new area of litigation.

Future studies should investigate the number of trial attorneys who have litigated a malpractice case within the past two years, and the number of pediatric dentists who have been involved with malpractice litigation within the past two years.

The data were analyzed with the Statistical Analysis System (SAS). The frequency distribution, percentage calculation, and chi-square analyses were appropriate for the data. Chi-square analyses of each question with age and population revealed no significant differences. Therefore, the comparison of frequency and percent was appropriate for the two groups of data.

The demographic analysis of the surveyed sample of Indiana pediatric dentists corresponded well with previous published findings.[91] The data from the pediatric dentists in this study are representative of the pediatric dentistry population in Indiana, and the collected data are believed to be reliable and valid.

No similar studies have surveyed Indiana trial attorneys. The age distribution, community practice population, and distribution of graduation from professional school of trial attorneys and pediatric dentists are similar in this study. Therefore, using inference, it is assumed that this sample of trial attorneys represents the population of trial attorneys practicing in Indiana.

Most pediatric dentists and trial attorneys seem to be moderately familiar with the doctrine of informed consent. A greater number of trial attorneys were extremely familiar with the doctrine than were pediatric dentists. Surprisingly, a few trial attorneys were unfamiliar with the doctrine.

Most trial attorneys think pediatric dentists do not conform to the requirements of the doctrine of informed consent. In contrast, most pediatric dentists think they do conform to the requirements of the doctrine of informed consent. Trial attorneys are presumably more knowledgeable in the legal requirements for a valid informed consent than are pediatric dentists.

Most trial attorneys and pediatric dentists recommend that oral informed consent be obtained and then documented on an informed consent form. Under some circumstances oral informed consent is adequate, but if litigation arises, the dentist will be faced with a witness v. witness credibility fight. Obtaining an oral informed consent and documenting this in written form will prevent this problem. If the process of obtaining an informed consent is properly performed, then most patients, parents and legal guardians should not be offended when presented with the informed consent form. Most patients will appreciate the process of obtaining informed consent because it contributes to improved communication and rapport.

There appears to be a need for more emphasis in dental schools and specialty training programs on the necessity of obtaining informed consent. Approximately 64.4 percent of pediatric dentists and 55.7 percent of trial attorneys either disagree or strongly disagree with the statement that a dental school education adequately prepares the pediatric dentist to obtain an informed consent. Additionally, 65.6 percent of pediatric dentists and 56.5 percent of trial attorneys either agree or strongly agree that specialty training programs adequately prepares the pediatric dentist to obtain an informed consent. Still, 27.6 percent of pediatric dentists and 42.1 percent of trial attorneys disagree with the statement. These data suggest that more time should be spent by educators teaching undergraduate and perhaps graduate students the fundamentals of obtaining a valid informed consent.

Pediatric dentists and trial attorneys appear to have an equal interest in the doctrine of informed consent. Approximately 28.8 percent of pediatric dentists and 28.8 percent of trial attorneys have taken continuing education courses which dealt with the doctrine of informed consent. Moreover, this may represent the small percentage of trial attorneys who specialize in medical malpractice, or those trial attorneys who have particular interest in this subject. The trend in obtaining additional continuing education on informed consent may explain why most pediatric

dentists and trial attorneys feel that pediatric dentists are more concerned with obtaining informed consent today than they were in the past. With increased malpractice litigation, it makes sense that the astute practitioner should be more concerned with the informed consent issue. A greater number of trial attorneys (96.7 percent) than pediatric dentists (83.1 percent) had this opinion. It is likely that trial attorneys have a greater appreciation than pediatric dentists do of the danger of litigation arising from a lack of informed consent. This reinforces the need for more informed consent education for the dentists.

The concern over malpractice litigation resulting in the practice of defensive dentistry and placing higher priority on obtaining informed consent affects the time spent by pediatric dentists when endeavoring to obtain valid informed consent. However, this study revealed that 55.9 percent of pediatric dentists feel that the time spent obtaining informed consent has remained the same, while 44.1 percent feel that the time has increased. Conversely, 81.5 percent of trial attorneys perceive that the pediatric dentist is spending more time obtaining informed consent. It seems that pediatric dentists may spend more time obtaining a valid informed consent as concern over malpractice litigation increases.

The amount of time that trial attorneys perceive pediatric dentists spend obtaining informed consent compares well with the amount of time pediatric dentists declare that they spend obtaining informed consent. The time spent obtaining an informed consent is considered to be less than five minutes (pediatric dentists: 66.1 percent; trial attorneys: 74.5 percent). Both groups agree that less than five minutes is adequate time to obtain a valid informed consent in most situations. However, some cases may involve more time due to increased complexities surrounding the treatment.

A portion of the questionnaire utilized in this study attempted to evaluate clinical knowledge and the application of informed consent. The findings reveal that the informed consent issue is not black and white. In attempting to compare trial attorneys and pediatric dentists as regards their knowledge of the Health Care Consent Law, both groups were asked for which patients they would recommend obtaining parental consent before providing any dental treatment. Both groups agreed that parental consent would be necessary when treating any minor, an incompetent minor, a 21-year-old mentally retarded patient, and a one-year-old infant of a 14-year-old mother. The Indiana Health Care Consent Law may require that consent be obtained in three out of the four situations. Whether consent would be needed from a parent of a 21-year-old mentally retarded

patient is questionable. A mentally retarded patient is legally competent to consent to health care unless the individual has been declared incompetent by a court, or has a court appointed legal guardian. Therefore, a 21-year-old mentally retarded patient may give consent for his or her own treatment; however, a court may later question the validity of the informed consent due to an inability to understand the consent on the part of the patient.

Whether consent is necessary from the parent of a mature minor falls within a grey area. Most pediatric dentists recommend parental consent. However, trial attorneys are split on whether parental consent is necessary. Trial attorneys seem to recognize the mature minors' rights to be informed and to be included in the decision-making process.

The Indiana Health Care Consent Law states that emancipated minors can give consent for treatment. One would expect that trial attorneys and pediatric dentists would not recommend obtaining parental consent in such cases. Minors become emancipated when they marry, become pregnant or are self-sufficient. Therefore, parental consent would not be needed for an emancipated minor, a pregnant minor, a married minor, and possibly a minor with no parent or guardian. In this study, trial attorneys concurred with the Health Care Consent Law. Trial attorneys were split 54.4 percent to 45.6 percent in favor of obtaining parental

consent when treating pregnant minors. On the other hand, pediatric dentists recommended obtaining parental consent for all four of the above situations. This shows that most pediatric dentists are not aware of the Health Care Consent Law and the correct application of the doctrine of informed consent to specific cases, are more conservative in their desire to prevent all potential risks of malpractice, or they choose to ignore the law.

The necessity to obtain parental consent when providing emergency treatment for minors is less clear. If the parent is present, it may be best always to obtain consent. If the parent is absent, as in the case of a runaway minor needing emergency care, each case must be evaluated individually. Fortunately, most runaways are in the custody of child governmental agencies when and if they present with a dental emergency, and the agencies have the legal right to provide informed consent. The literature states that emergency care may be provided without consent if the emergency is either life threatening or the lack of treatment can cause irreparable harm. The pediatric dentist should recognize that one viewpoint holds that no dental emergency fits this category, and therefore, parental consent would be required. Most pediatric dentists recommend parental consent when faced with a runaway minor, or with a minor presenting as an emergency. However, most trial attorneys

do not recognize the necessity of parental consent. As a last resort, it is reasonable for the pediatric dentist to petition a court for the appointment of a legal guardian for a runaway minor, if dental treatment is indicated. It seems prudent, in any case, to delay definitive, non-life-threatening emergency treatment until parental consent is obtained.

An interesting part of the study was the comparison between pediatric dentists and trial attorneys concerning the type of consent that is recommended for different dental procedures (Table XVII). The results can be broken down into two major groups with seven subdivisions. The first group, with trial attorneys and pediatric dentists agreeing on the type of consent, has been broken down into three subdivisions (Table XIX):

1. Implied consent (two procedures);
2. Oral informed consent (six procedures); and
3. Written informed consent (12 procedures).

The second group, with trial attorneys (TA) and pediatric dentists (PD) disagreeing on the type of consent, has four subdivisions (Table XX):

1. TA: Written informed consent,
   PD: Oral informed consent (14 procedures);
2. TA: Implied consent,
   PD: Oral informed consent (one procedure);

3. TA: Oral informed consent,

   PD: Implied consent (one procedure); and

4. TA: Written informed consent,

   PD: Implied consent (one procedure).

The risks and complexities associated with a dental procedure appear to influence the type of consent perceived to be necessary. Pediatric dentists and trial attorneys agree that implied consent is adequate for procedures with few or no risks and in cases of life-threatening emergencies. An oral examination is included in this subdivision. The amount of risk associated with an examination is minimal. However, more complex treatment with greater risks necessitates a more detailed consent. Pediatric dentists and trial attorneys agree that an oral informed consent is adequate for over-the-counter drugs, hand over mouth exercise, topical fluoride, restorations, radiographs, and extraction of a loose primary tooth. Pediatric dentists and trial attorneys agree that a written informed consent is necessary for orthodontics, oral surgery, use of any dangerous drug or chemical, periodontal surgery, oral sedation, I.M. sedation, I.V. sedation, general anesthesia, a photograph for publication, a photograph for group presentations, an experimental procedure, and an oral examination for research.

Disagreement about the type of consent between pediatric dentists and trial attorneys for specific dental procedures is a more disturbing problem. It is probable that

future informed consent litigation may involve the application of these procedures more than the aformentioned procedures. It appears that the disagreements between the two professional groups can be resolved in a simple manner. The first area of disagreement involves a prophylaxis. Pediatric dentists recommend oral informed consent while trial attorneys recommend implied consent. First, the pediatric dentist must consider the risks of a prophylaxis. Second, the pediatric dentist must establish the need for a specific consent based on those risks. The risks of a prophylaxis for a patient with an essentially negative medical history are minimal or non-existent. Therefore, implied consent may be adequate for a prophylaxis.

In contrast, pediatric dentists recommend implied consent and trial attorneys recommend oral informed consent for the use of mouth props. Implied consent may not be adequate for the use of mouth props because they are not used routinely in pediatric dentistry and are a type of restraining device that can inflict soft and hard tissue trauma. It would not be surprising for a parent or patient to object to their use. Therefore, the clinician may benefit by following the advice of trial attorneys and obtain an oral informed consent for the use of mouth props. The use of expanded function dental auxiliaries has become essential to the cost-effective delivery of routine pediatric

dental care. It is probable that many parents are not aware of the procedures that these highly trained auxiliaries are able to perform. To the pediatric dentist, implied consent is adequate for their use in the office. Are there risks involved with the use of expanded function dental auxiliaries? Can these auxiliaries increase the risks inherent in certain procedures? What about the case where a parent demands that the pediatric dentist place the restoration and not the expanded function dental auxiliary? Would such a non-authorized touching of their child's body by the auxiliary be a battery? Trial attorneys and pediatric dentists would likely view this situation differently. It seems that a written informed consent should be obtained when expanded function dental auxiliaries provide services that were formerly limited to dentists by state dental laws.

The last subdivision is the least controversial. Pediatric dentists recommend obtaining an oral informed consent and trial attorneys recommend obtaining a written informed consent for the following dental procedures: crowns, extraction of infected primary teeth, extraction of permanent teeth, root canal treatment, pulp therapy on primary teeth, space maintenance, prescription for controlled substances, local anesthesia in the office, the use of restraining devices, use of hand over mouth restricted airway, use of auxiliary restraint, use of any behavior management

technique, non-life-threatening emergencies, and the use of nitrous oxide. The process of obtaining informed consent is equally time-consuming, whether in the oral or written form. Therefore, it may be best for pediatric dentists to obtain oral informed consent for these procedures and then document it in written form as recommended by trial attorneys.

Trial attorneys have particular insight, which probably differs from that of pediatric dentists, into the recent rise in malpractice litigation. In this study, 85.1 percent of trial attorneys and 63.8 percent of pediatric dentists felt that pediatric dentists can reduce or eliminate future malpractice litigation by conforming to the doctrine of informed consent. Thirty-six percent of pediatric dentists felt that conforming to the doctrine would not affect malpractice litigation. Adhering to the doctrine of informed consent, establishing good communication and rapport, advising parents on what you are planning to do, advising of risks, possible complications and alternatives available should decrease the malpractice crisis. If conforming to the doctrine prevents one malpractice suit from being filed during the lifetime of a pediatric dentist, then it is worth developing the habit of obtaining a valid informed consent from every patient, when possible.

SUMMARY AND CONCLUSIONS

This study was designed to compare and analyze the viewpoints of Indiana pediatric dentists and trial attorneys concerning the doctrine of informed consent.

The primary purpose was to provide insight on how pediatric dentists obtain informed consent, on how trial attorneys recommend obtaining informed consent, and on changing trends in the pediatric dental office with regard to the doctrine of informed consent. The ultimate goal was to acquaint each of the two professional groups with the views of the other concerning the doctrine of informed consent, and, specifically, to raise the level of awareness of the doctrine among pediatric dentists.

Overall, most pediatric dentists and trial attorneys were moderately familiar with the doctrine of informed consent. However, trial attorneys do not feel that pediatric dentists conform to the doctrine, while pediatric dentists perceive that they do conform. Pediatric dentists and trial attorneys recommend that informed consent be obtained orally and documented on an informed consent form. Both professional groups agree that obtaining informed consent is necessary in the practice of pediatric dentistry. Unfortunately, pediatric dentists and trial attorneys do not feel that either predoctoral dental school

education or specialty training prepares the pediatric dentist to obtain an informed consent. Not surprisingly, both groups feel that pediatric dentists are more concerned with obtaining informed consent today than they were in the past. Most pediatric dentists are obtaining informed consent in less than five minutes. However, pediatric dentists feel that the time spent obtaining informed consent has either remained the same (55.9 percent) or increased (44.1 percent); trial attorneys feel that this trend has increased (81.5 percent). Overall, pediatric dentists and trial attorneys disagree on whether parental consent is required for specific patient types. The two groups agree on the type of consent necessary for 20 dental procedures (54 percent) and disagree on 17 dental procedures (46 percent). Finally, most trial attorneys and pediatric dentists feel that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation.

This study will, hopefully, stimulate further study of malpractice litigation, informed consent, and the dental profession's appreciation of these issues. It may be viewed as the first step in closing the communications gap that apparently exists between trial attorneys and pediatric dentists.

As a result of this investigation, the following recommendations are proposed:

1. There is a need to duplicate this study and validate the data obtained from these samples of Indiana trial attorneys and pediatric dentists;

2. A study should be initiated which will investigate the pediatric dentist's knowledge of the doctrine of informed consent and compare it with similar data obtained from trial attorneys;

3. The number of trial attorneys who have filed a malpractice case and the number of pediatric dentists who have been involved with malpractice litigation within the past two years should be ascertained;

4. Similar studies should be initiated in other legal jurisdictions throughout the nation to see if they follow the trends seen in Indiana;

5. Dental school curricula and specialty training programs should incorporate more information in jurisprudence, with more attention to informed consent and the technique of obtaining a valid informed consent;

6. It may be adequate to obtain implied consent for oral examinations, prophylaxes, and for life-threatening emergencies;

7. The pediatric dentist may benefit by obtaining an oral informed consent for over-the-counter drugs, hand over mouth exercise, topical fluoride, restorations, radiographs, and extraction of loose primary teeth; and

8. Pediatric dentists may benefit by obtaining a written informed consent for orthodontics, oral surgery, use of any dangerous drug or chemical, periodontal surgery, oral sedation, I.M. sedation, I.V. sedation, general anesthesia, a photograph for publication, a photograph for group presentations, an experimental procedure, an oral examination for research, use of mouth props, expanded function dental auxiliaries, crowns, extraction of infected primary teeth, extraction of permanent teeth, root canal treatment, pulp therapy on primary teeth, space maintenance, prescriptions for controlled substances, local anesthesia in the office, the use of restraining devices, use of hand over mouth restricted airway, use of auxiliary restraint, use of any behavior management technique, non-life-threatening emergencies, and the use of nitrous oxide.

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APPENDIXES

shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of any person that placed the patient in a terminal condition and the patient's death. *As added by P.L.176-1985, SEC.1.*

16-8-11-22 Violation by physician; discipline

Sec. 22. A physician who knowingly violates this chapter is subject to disciplinary sanctions under IC 25-22.5-6-2.1 as if the physician had knowingly violated a rule adopted by the medical licensing board under IC 25-22.5-2-7. *As added by P.L.176-1985, SEC.1.*

Chapter 12. Health Care Consent Law.

16-8-12-1 Definitions

Sec. 1. As used in this chapter:

(1) "Adult" means an individual who is at least eighteen (18) years of age.

(2) "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. The term includes admission to a health care facility.

(3) "Health care provider" has the meaning set forth in IC 16-9.5-1-1. The term also includes a health facility as defined in IC 16-10-4-2.

(4) "Minor" means an individual who is not an adult.

(5) "Representative" means an individual appointed to consent to health care of another under this chapter.

As added by P.L.205-1987, SEC.1.

16-8-12-2 Consent to health care

Sec. 2. Unless incapable of consenting under section 3 of this chapter, an individual may consent to the individual's own health care if the individual is:

(1) an adult; or

(2) a minor and:

(A) is emancipated;

(B) is at least fourteen (14) years of age, is not dependent on a parent for support, is living apart from the minor's parents or from an individual in loco parentis, and is managing the minor's own affairs;

(C) is or has been married;

(D) is in the military service of the United States; or

(E) is authorized to consent to the health care by any other statute.

As added by P.L.205-1987, SEC.1.

16-8-12-3 Incapacity to consent; invalid consent

Sec. 3. (a) An individual otherwise authorized under this chapter may consent to health care unless, in the good faith opinion of the attending physician, the individual is incapable of making a decision regarding the proposed health care.

(b) A consent to health care under section 4, 5, or 6 of this chapter is not valid if the health care provider has knowledge that the individual has indicated contrary instructions in regard to the proposed health care, even if the individual is believed to be incapable of making a decision regarding the proposed health care at the time the individual indicates contrary instructions. *As added by P.L.205-1987, SEC.1.*

16-8-12-4 Individuals authorized to consent for incapable parties; minors

Sec. 4. (a) If an individual incapable of consenting under section 3 of this chapter has not appointed a health care representative under section 6 of this chapter or the health care representative appointed under section 6 of this chapter is not reasonably available or declines to act, consent to health care may be given:

(1) by a judicially appointed guardian of the person or a representative appointed under section 7 of this chapter;

(2) by a spouse, parent, adult child, or adult sibling unless disqualified under section 8 of this chapter, if:

(A) there is no guardian or other representative described in subdivision (1);

(B) the guardian or other representative is not reasonably available or declines to act; or

(C) the existence of the guardian or other representative is unknown to the health care provider; or

(3) by the individual's religious superior, if the individual is a member of a religious order and:

(A) there is no guardian or other representative described in subdivision (1);

(B) the guardian or other representative is not reasonably available or declines to act; or

(C) the existence of the guardian or other representative is unknown to the health care provider.

(b) Consent to health care for a minor not authorized to consent under section 2 of this chapter may be given:

(1) by a judicially appointed guardian of the person or a representative appointed under section 7 of this chapter;

(2) by a parent or an individual in loco parentis, if:

(A) there is no guardian or other representative described in subdivision (1);

(B) the guardian or other representative is not reasonably available or declines to act; or

(C) the existence of the guardian or other representative is unknown to the health care provider; or

(3) by an adult sibling of the minor, if:

(A) there is no guardian or other representative described in subdivision (1);

(B) a parent or an individual in loco parentis is not reasonably available or declines to act;

(C) the existence of the parent or individual in loco parentis is unknown to the health care provider.

(c) An individual delegated authority to consent under section 5 of this chapter has the same authority and responsibility as the individual delegating the authority.

(d) An individual authorized to consent for another under this section shall act in good faith and in the best interest of the individual incapable of consenting. *As added by P.L.205-1987, SEC.1.*

16-8-12-5 Delegated authority to consent on behalf of incapable party

Sec. 5. (a) An individual authorized to consent to health care for another under section 4(a)(2), 4(b)(2), or 4(b)(3) of this chapter who for a period of time will not be reasonably available to exercise the authority may delegate the authority to consent during that period to another not disqualified under section 8 of this chapter. The delegation must be in writing, signed, and witnessed by an adult, and it may specify conditions on the authority delegated. Unless the writing expressly provides otherwise, the delegate may not delegate the authority to another.

(b) The delegant may revoke the delegation at any time by notifying orally or in writing the delegate or the health care provider. *As added by P.L.205-1987, SEC.1.*

16-8-12-6 Appointed representative; qualifications; conditions; effective date; duties; resignation; revocation of appointment

Sec. 6. (a) An individual who may consent to health care under section 2 of this chapter may appoint another as a representative to act for the appointor in matters affecting the appointor's health care.

(b) A representative appointed under this section must be an individual who may consent to health care under section 2 of this chapter.

(c) An appointment and any amendment thereto must be:

(1) in writing;

(2) signed by the appointor or by a designee in the appointor's presence; and

(3) witnessed by an adult other than the representative.

(d) The appointor may specify in the appointment terms and conditions considered appropriate, including an authorization to the representative to delegate the authority to consent to another.

(e) The authority granted becomes effective according to the terms of the appointment.

(f) The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the appointor becomes capable of consenting.

(g) Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the appointor, except when the appointor is capable of consenting.

(h) In making all decisions regarding the appointor's health care, a representative appointed under this section shall act:

(1) in the best interest of the appointor consistent with the purpose expressed in the appointment; and

(2) in good faith.

(i) A health care representative who resigns or is unwilling to comply with the written appointment may exercise no further power under the appointment and shall so inform:

(1) the appointor;

(2) the appointor's legal representative, if one is known; and

(3) the health care provider, if the representative knows there is one.

(j) An individual who is capable of consenting to health care may revoke:

(1) the appointment at any time by notifying the representative orally or in writing; or

(2) the authority granted to the representative by notifying the health care provider orally or in writing.

As added by P.L.205-1987, SEC.1.

16-8-12-7 Probate court petition; hearing; notice; findings

Sec. 7. (a) A health care provider or any interested individual may petition the probate court (which means the court having jurisdiction under IC 29-1-18-4 in the county where the individual is present for purposes of receiving health care) to:

(1) make a health care decision or order health care for an individual incapable of consenting; or

(2) appoint a representative to act for that individual.

(b) Reasonable notice of time and place of hearing a petition under this section must be given to the individual incapable of consenting, to anyone having the care and custody of the individual, and to those individuals in the classes described in section 4 of this chapter who are reasonably available and who are designated by the court.

(c) The probate court may modify or dispense with notice and hearing if it finds that delay will have a serious, adverse effect upon the health of the individual.

(d) The probate court may order health care, appoint a representative to make a health care decision for the individual incapable of consenting to health care with such limitations on the authority of the representative as it considers appropriate, or order any other appropriate

relief in the best interest of that individual, if it finds:

(1) a health care decision is required for the individuals;

(2) the individual is incapable of consenting to health care; and

(3) there is no individual authorized to consent or an individual authorized to consent to health care is not reasonably available, declines to act, or is not acting in the best interest of the individual in need of health care.

As added by P.L.205-1987, SEC.1.

16-8-12-8 Disqualification to consent

Sec. 8. (a) An individual who may consent to the individual's own health care under section 2 of this chapter may disqualify others from consenting to health care for the individual.

(b) The disqualification must be in writing, signed by the individual, and designate those disqualified.

(c) A health care provider who knows of a written disqualification may not accept consent to health care from a disqualified individual.

(d) An individual who knows that the individual has been disqualified to consent to health care for another may not act for the other under this chapter. *As added by P.L.205-1987, SEC.1.*

16-8-12-9 Immunity of health care providers or consenting persons; good faith requirement

Sec. 9. (a) A health care provider acting or declining to act in reliance on the consent or refusal of consent of an individual who the provider believes in good faith is authorized by this chapter or another statute to consent to health care is not subject to criminal prosecution, civil liability, or professional disciplinary action on the ground that the individual who consented or refused to consent lacked authority or capacity.

(b) A health care provider who believes in good faith that an individual is incapable of consenting is not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to follow that individual's direction.

(c) A person who in good faith believes the person is authorized to consent or refuse to consent to health care for another under this chapter or another statute is not subject to:

(1) criminal prosecution; or

(2) civil liability, if the person exercises due care;

on the ground that the person lacked authority to consent. *As added by P.L.205-1987, SEC.1.*

16-8-12-10 Disclosure of medical information to individual authorized to consent

Sec. 10. An individual authorized to consent to health care for another under this chapter has the same right as does the other for whom the individual is acting to receive information relevant to the contemplated health care and to consent to the disclosure of medical records to a health care provider. Disclosure of information regarding contemplated health care to an individual authorized to consent for another is not a waiver of an evidentiary privilege or of the right to assert confidentiality. *As added by P.L.205-1987, SEC.1.*

16-8-12-11 Exceptions; personal liability of representatives for costs of care

Sec. 11. (a) This chapter does not affect Indiana law concerning an individual's authorization to make a health care decision for the individual or another individual, or to provide, withdraw, or withhold medical care necessary to prolong or sustain life.

(b) This chapter does not affect the requirements in any other Indiana law concerning consent to observation, diagnosis, treatment, or hospitalization for a mental illness.

(c) This chapter does not authorize an individual to consent to any health care that is prohibited under Indiana law.

(d) This chapter does not affect any requirement of notice to others of proposed health care under any other Indiana law.

(e) This chapter does not affect Indiana law concerning:

(1) the standard of care of a health care provider required in the provision of health care;

(2) when consent is required for health care;

(3) elements of informed consent for health care;

(4) other methods of consent authorized by law; or

(5) health care being provided in an emergency without consent.

(f) This chapter does not prevent an individual capable of consenting to the individual's own health care, or to the health care of another, under this chapter, including those authorized under sections 4 through 6 of this chapter, from consenting to health care administered in good faith pursuant to religious tenents of the individual requiring health care.

(g) A representative consenting to health care for an individual under this chapter does not become personally liable for the cost of the health care by virtue of that consent. *As added by P.L.205-1987, SEC.1.*

16-8-12-12 Euthanasia

Sec. 12. Nothing in this chapter may be construed to authorize euthanasia. *As added by P.L.205-1987, SEC.1.*

ARTICLE 9.5. MEDICAL MALPRACTICE

Chapter 1. Definitions and General Applications.

16-9.5-1-1 Definitions

Sec. 1. As used in this article:

(a) "Health care provider" means:

(1) an individual, partnership, corporation, professional corporation, facility, or institution licensed or legally authorized by this state to provide health care or professional services as a physician, psychiatric hospital, hospital, health facility, dentist, registered or licensed practical nurse, midwife, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or as an officer, employee, or agent thereof acting in the course and scope of his employment;

(2) any college, university, or junior college which provides health care to any student, faculty member, or employee, and the governing board or any officer, employee, or agent thereof acting in the course and scope of his employment;

(3) a blood bank, community mental health center, community mental retardation center, community health center, or migrant health center;

(4) a home health agency, as defined under IC 16-10-2.5-1;

(5) a prepaid health care delivery plan, as defined in IC 27-8-7-1(h);

(6) a health care organization whose members, shareholders, or partners are health care providers under subdivision (1);

(7) a corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) as one (1) of its functions, provides health care;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under this chapter for its health care function.

Coverage for a health care provider qualified under this subdivision is limited to its health care functions and does not extend to other causes of action.

146, SEC.1). As amended by Acts 1976, P.L.65, SEC.1; Acts 1979, P.L.152, SEC.1; Acts 1982, P.L.120, SEC.1; P.L.105-1984, SEC.1; P.L.177-1985, SEC.1; P.L.28-1985, SEC.19; P.L.133-1986, SEC.1; P.L.206-1987, SEC.1.

16-9.5-1-4 Liability based on contract; consent of patient; requirements; withdrawal; exceptions

Sec. 4. (a) No liability shall be imposed on a health care provider on the basis of an alleged breach of contract, express or implied, assuring results to be obtained from any procedure undertaken in the course of health care, unless that contract is in writing and signed by that health care provider or by an authorized agent of that health care provider.

(b) If a patient's written consent is:

(1) signed by the patient or the patient's authorized representative;

(2) witnessed by an individual at least eighteen (18) years of age; and

(3) explained, orally or in the written consent, to the patient or the patient's authorized representative before a treatment, procedure, examination, or test is undertaken;

a rebuttable presumption is created that the consent is an informed consent.

(c) The explanation given in accordance with subsection (b)(3) must include the following information:

(1) The general nature of the patient's condition.

(2) The proposed treatment, procedure, examination, or test.

(3) The expected outcome of the treatment, procedure, examination, or test.

(4) The material risks of the treatment, procedure, examination, or test.

(5) The reasonable alternatives to the treatment, procedure, examination, or test.

(d) This section does not relieve a qualified health care provider of the duty to obtain an informed consent.

(e) This section does not prevent a patient, after having signed a consent, from withdrawing that consent.

(f) This section does not require that a patient's consent or the information described under subsection (c) be in writing in all cases.

(g) Compliance with this section is not required in order to create an informed consent.

(h) A patient may refuse to receive some or all of the information described in subsection (c).

(i) Subsections (b) and (c) do not apply to a person who is mentally incapable of understanding the information required to be provided by subsection (c). This subsection does not require consent to health care in an emergency. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.207-1987, SEC.1.*

16-9.5-1-6 Pleadings; right of jury trial

Sec. 6. Subject to IC 16-9.5-9, a patient or his representative having a claim under this article for bodily injury or death on account of malpractice may file a complaint in any court of law having requisite jurisdiction and demand right of trial by jury. Except for the declaration called for in IC 16-9.5-9-2.1(a), no dollar amount or figure shall be included in the demand in any malpractice complaint, but the prayer shall be for such damages as are reasonable in the premises. *(Formerly: Acts 1975, P.L.146, SEC.1). As amended by P.L.178-1985, SEC.1.*

16-9.5-1-8 Repealed.

Sec. 8. *(History: Repealed, as added by Acts 1976, P.L.65, SEC.2, and as added by P.L.177-1985, SEC.2, by P.L.19-1986, SEC.31).*

16-9.5-1-9 Malpractice claims against governmental entity or its employer; article to govern

Sec. 9. A claim based on an occurrence of malpractice against a governmental entity or an employee of a governmental entity, as those terms are defined in IC 34-4-16.5, shall be governed exclusively by this article if the governmental entity or employee is qualified under this article. *As added by P.L.19-1986, SEC.32.*

APPENDIX 2

Miller's[83] Advantages of a Survey Questionnaire

1. They afford wider geographic contact.
2. Greater coverage may yield greater validity through larger and more representative samples.
3. They permit more considered answers.
4. They are adequate in situations in which the respondent must check his information.
5. They provide for greater uniformity in the manner in which questions are posed.
6. They give the respondent a sense of privacy.
7. They lesson adverse interviewer affect.

APPENDIX 3

Norusis'89 Tips to Follow When Designing a Survey Questionnaire

1. Indicate a specific place on the form to record each piece of information.
2. Record the actual values for numeric values.
3. If necessary, assign codes to possible answers.
4. Assign special codes for missing or unavailable information.
5. Split up complicated questions into parts.
6. Make sure the data can be entered into a computer directly from the form.

APPENDIX 4

Allen's[87] Guidelines for the Construction of an Effective Survey Questionnaire

1. The length of your questionnaire is critical to the success of your data collection. The longer the form, the greater the reluctance of the potential respondent to respond.
2. Try to reduce to a minimum the time required to complete the form.
3. Reducing the number of pages makes it appear that less time will be required to complete the form.
4. If a personal piece of information is not necessary for your study, omit it from the form.
5. Pretest the questionnaire if at all possible.
6. Word each question as simply, clearly, straightforwardly and briefly as possible.
7. Be aware of the "central-tendency" concept; solve the problem by using an even number of categories for your questions, thereby forcing the respondent to take one side or the other.
8. If appropriate for your research, favor the use of closed-ended questions.
9. Include demographic factors if appropriate and relevant to your research.
10. Relate each question on the form to the purpose of your research or to some specific chapter in your proposed table of contents.
11. Anticipate what you will do with the data once you have it in your hands.
12. Consider carefully the sequence in which questions appear on the questionnaire.
13. If possible, build an "internal-consistancy check" into the questionnaire (for example, two questions that should be answered in a similar or an opposite manner).

APPENDIX 5

Miller's[83] Guidelines for the Construction of an Effective Survey Questionnaire

1. Have a clear picture of what you are seeking to find.

2. Formulate questions:
   a) Use familiar language and terminology.
   b) Pick words that have the same meaning to everyone.
   c) Avoid long questions.
   d) Do not assume that your respondent possesses factual information or first hand opinions.
   e) Establish the frame of reference you have in mind.
   f) Either suggest all possible alternatives to a question or don't suggest any.
   g) Protect your respondent's ego.
   h) If you're after unpleasant orientations, give your respondent a chance to express his positive feelings first so he is not put in an unfavorable light.
   i) Decide whether you need a direct or indirect question.
   j) Decide whether the question should be open or closed.
   k) Decide whether general or specific questions are needed.
   l) Avoid ambiguous wording.
   m) Avoid biased or leading questions.
   n) Phrase questions so they are not unnecessarily objectionable.
   o) Decide whether a personal or impersonal question will obtain better results.
   p) Questions should be limited to a single idea or reference.

3. Organize the questionnaire with the previous points in mind.

4. Pretest the questionnaire.

5. Select paper and type carefully.

6. Consider how you can present the strongest possible sponsorship. The group that will support your efforts through a cover letter is important.

7. Examine each of the techniques for increasing return of the questionnaire and decide which will maximize returns for you.

APPENDIX 6

Allen's[87] Recommendations to Increase the Return Rate of Survey Questionnaires

1. Design the questionnaire in such a fashion that you are able to encourage respondents to complete it.

2. Ask yourself who should receive the questionnaires? Use care in the selection process, so that the form goes to those most likely to respond.

3. Determine the proper time to make the mailing.

4. Establish a reasonable deadline for the return of the questionnaire. An open date does not encourage a response. An unrealistic return date may irritate the potential respondent. In setting a realistic deadline, consider vacation schedules and seasonal demands on your particular respondents.

5. Use a follow-up letter if this technique is appropriate for the type of study you are conducting.

6. Identify yourself as a doctoral student if, after a discussion with your research chairman, you believe such identification will increase the rate of return.

7. Consider including an appropriate cover letter from you or your research chairman or someone who might carry some weight with the respondent.

8. Keep the questionnaire to a reasonable length.

9. If feasible, offer potential respondents a summary of your findings - a copy of your abstract or a special summary prepared for respondents.

10. Consider using the school's stationery (with permission) or any other "official" stationery that might improve your chances for increasing the return rate.

INDIANA UNIVERSITY HOSPITALS

DEPARTMENT OF PEDIATRIC DENTISTRY
James Whitcomb Riley Hospital for Children
702 Barnhill Drive, Room 1162
Indiana University Medical Center
Indianapolis, Indiana 46223
(317) 274-8492

APPENDIX 7

January 15, 1988

Name
Address
City, State Zip Code

Dear Dr.:

I am a postgraduate student specializing in pediatric dentistry at the Indiana University School of Dentistry. As part of the requirements for a Master of Science in Dentistry degree, I am pursuing a thesis project which will analyze the doctrine of informed consent.

You have been specifically selected to participate in this survey as a representative of Indiana pediatric dentists. The main purpose of this study is to compare and evaluate the views of pediatric dentists and trial attorneys with the doctrine of informed consent.

The enclosed questionnaire has been carefully designed to be completed within 10 minutes. Your responses will remain completely anonymous.

A self-addressed and stamped envelope has been enclosed for your convenience.

I anticipate publishing the results of this study in the dental and legal literature. The results will also be available through the Indiana University School of Dentistry Library.

If you have any questions concerning the project, please feel free to contact me at (317) 274-8492.

Thank you for your participation in this project.

Sincerely,

Michael A. Buccino, D.D.S.

PLEASE RETURN BY JANUARY 29, 1988

APPENDIX 8

SURVEY QUESTIONNAIRE FOR THE PEDIATRIC DENTIST

1. Age:

Less than 30 ....._____
30-39 ....._____
40-49 ....._____
50-59 ....._____
More than 59 ....._____

2. Population of the community where your practice is located:

Greater than 100,000 .._____
25,000-100,000 ....._____
5,000-25,000 ....._____
Less than 5,000 ....._____

3. Year of graduation from professional school:

Dental school ....._____
Postgraduate training ._____
Certificate alone ....._____
Master's degree with certificate ..._____

4. How familiar are you with the doctrine of informed consent?:

Extremely familiar ....._____
Moderately familiar ....._____
Vaguely familiar ....._____
Unfamiliar ....._____

5. Do you feel that the average pediatric dentist conforms to the doctrine of informed consent?:

Yes ....._____
No ....._____

6. How do you inform your patients and obtain their consent for treatment?:

Oral only ....._____
Oral and verified in dental record ....._____
Oral and the use of an informed consent form ..._____

7. Do you feel that the duty to obtain an informed consent is necessary in the practice of pediatric dentistry?:

Yes ....._____
No ....._____

8. Your undergraduate dental school training adequately prepared you to obtain informed consent.:

Strongly agree _____ Agree _____ Disagree _____ Strongly Disagree _____

9. Your postgraduate pediatric training adequately prepared you to obtain informed consent.:

Strongly agree _____ Agree _____ Disagree _____ Strongly Disagree _____

10. Have you attended continuing education courses which dealt with the doctrine of informed consent?:

Yes .....
When _____
No .....

11. Are you more concerned with obtaining informed consent today than you were in the past?:

Yes .....
No .....

12. Time spent on obtaining informed consent in your office over the last few years has:

Decreased _____ Remained the same _____ Increased _____

13. How much of your time is spent obtaining informed consent on each patient (estimate)?:

None .....
Less than 5 minutes .....
6-10 minutes .....
11-15 minutes .....
16-20 minutes .....
Greater than 20 minutes .....

14. For which of the following patients would you obtain parental consent before providing any dental treatment (check all that may apply):

Any minor .....
A mature minor (14 years-18 years) .....
An emancipated minor .....
An incompetent minor .....
A pregnant minor .....
A married minor .....
A minor presenting as an emergency .....
A minor with no parent or guardian .....
A runaway minor .....
A 21-year-old severely mentally retarded patient.
A one-year-old infant of a 14-year-old mother ...

15. Check the type of consent you would recommend for each treatment listed below:

	Implied Consent	Oral Informed Consent	Written Informed Consent
Examinations			
Prophylaxis			
Topical fluoride			
Radiographs			
Restorations			
Crowns			
A photograph for publication			
A photograph for group presentations			
An experimental procedure			
An oral examination for research			
Extraction of a loose primary tooth			
Extraction of an infected primary tooth			
Extraction of a permanent tooth			
Root canal treatment			
Pulp therapy on a primary tooth			
Space maintenance			
Orthodontics			
Oral surgery			
Recommendation for over-the-counter drugs			
Prescription for controlled substances			
Use of local anesthesia in the office			
Use of any dangerous drug or chemical			
Periodontal surgery			
Oral sedation			
Nitrous oxide			
I.M. sedation			
I.V. sedation			
Treatment under general anesthesia			
Use of expanded function dental auxiliaries			
Use of restraining devices			
Use of hand over mouth exercise (HOME)			
Use of hand over mouth restricted airway			
Use of mouth props			
Use of auxiliary restraint			
Use of any behavior management technique			
Life-threatening emergencies			
Non-life-threatening emergencies			

16. Do you feel that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation?:

Yes ....._____
No ....._____

17. Additional Comments:

INDIANA UNIVERSITY

SCHOOL OF LAW
INDIANAPOLIS

OFFICES OF THE FACULTY
735 West New York Street
Indianapolis, Indiana 46202
(317) 274-8523

APPENDIX 9

February 3, 1988

Name
Address
City, State Zip Code

Dear:

I am a postgraduate student specializing in pediatric dentistry at the Indiana University School of Dentistry. As part of the requirements for a Master of Science in Dentistry degree, I am pursuing a thesis project which will analyze the doctrine of informed consent.

Professor Henry C. Karlson, faculty at Indiana University School of Law, is a member of my thesis committee and has an interest in this study.

You have been specifically selected to participate in this survey as a representative of Indiana trial attorneys. The main purpose of this study is to compare and analyze the views of pediatric dentists and trial attorneys with the doctrine of informed consent.

The enclosed questionnaire has been carefully designed to be completed within 10 minutes. Your responses will remain completely anonymous.

A self-addressed and stamped envelope has been enclosed for your convenience.

I anticipate publishing the results of this study in the dental and legal literature. The results will also be available through the Indiana University School of Dentistry Library.

If you have any questions concerning the project, please feel free to contact me at (317) 274-8492.

Thank you for your participation in this project.

Sincerely,

Michael A. Buccino, D.D.S.

PLEASE RETURN BY FEBRUARY 12, 1988

APPENDIX 10

SURVEY QUESTIONNAIRE FOR THE TRIAL ATTORNEY

1. Age:

Less than 30 ....._____
30-39 ....._____
40-49 ....._____
50-59 ....._____
More than 59 ....._____

2. Population of the community where your practice is located:

Greater than 100,000 .._____
25,000-100,000 ....._____
5,000-25,000 ....._____
Less than 5,000 ....._____

3. Year of graduation from professional school:

Law school ....._____
Postgraduate training ._____
Type of degree(s) ....._____

4. How familiar are you with the doctrine of informed consent?:

Extremely familiar ....._____
Moderately familiar ....._____
Vaguely familiar ....._____
Unfamiliar ....._____

5. Do you feel that the average pediatric dentist conforms to the doctrine of informed consent?

Yes ....._____
No ....._____

6. How should the pediatric dentist inform his patients and obtain their consent for treatment?:

Oral only ....._____
Oral and verified in dental record ....._____
Oral and the use of an informed consent form ..._____

7. Do you feel that the duty to obtain an informed consent is necessary in the practice of pediatric dentistry?:

Yes ....._____
No ....._____

8. The undergraduate dental school training adequately prepares the dental student to obtain informed consent.:

Strongly agree _____ Agree _____ Disagree _____ Strongly Disagree _____

9. The postgraduate pediatric training adequately prepares the pediatric dentist to obtain informed consent.:

Strongly agree _____ Agree _____ Disagree _____ Strongly Disagree _____

10. Have you attended continuing education courses which dealt with the doctrine of informed consent?:

Yes ....._____
When _____
No ....._____

11. Do you think that pediatric dentists are more concerned with obtaining informed consent today than they were in the past?:

Yes ....._____
No ....._____

12. Time spent on obtaining informed consent in a pediatric dental office over the last few years has probably:

Decreased _____ Remained the same _____ Increased _____

13. How much of a pediatric dentist's time do you think is spent obtaining informed consent on each patient (estimate)?:

None ....._____
Less than 5 minutes ....._____
6-10 minutes ....._____
11-15 minutes ....._____
16-20 minutes ....._____
Greater than 20 minutes ....._____

14. For which of the following patients would you recommend that the pediatric dentist obtain parental consent before providing any dental treatment (check all that may apply):

Any minor ....._____
A mature minor (14 years-18 years) ....._____
An emancipated minor ....._____
An incompetent minor ....._____
A pregnant minor ....._____
A married minor ....._____
A minor presenting as an emergency ....._____
A minor with no parent or guardian ....._____
A runaway minor ....._____
A 21-year-old severely mentally retarded patient._____
A one-year-old infant of a 14-year-old mother ..._____

15. Check the type of consent you would recommend for each treatment listed below:

	Implied Consent	Oral Informed Consent	Written Informed Consent
Examinations			
Cleanings			
Topical fluoride			
X-Rays			
Fillings			
Silver Crowns			
A photograph for publication			
A photograph for group presentations			
An experimental procedure			
An oral examination for research			
Extraction of a loose baby tooth			
Extraction of an infected baby tooth			
Extraction of a permanent tooth			
Root canal treatment			
Root canal treatment in baby teeth			
Spacer for missing baby teeth			
Orthodontics			
Oral surgery			
Recommendation for over-the-counter drugs			
Prescription for controlled medicines			
Use of "Novocaine" in the office			
Use of any dangerous drug or chemical			
Gum surgery			
Sedative drugs by mouth			
Laughing Gas			
Injection of drugs into muscle			
Injection of drugs into veins			
Treatment under general anesthesia			
Use of dental auxiliaries to place fillings			
Physically restraining patients			
Use of hand over mouth exercise (HOME)			
Use of hand over mouth restricted airway			
Use of devices to hold mouths open			
Use of restraint by auxiliaries			
Use of any behavior management technique			
Life-threatening emergencies			
Non-life-threatening emergencies			

16. Do you feel that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation?:

Yes ....._____
No ....._____

17. Additional Comments:

APPENDIX 11

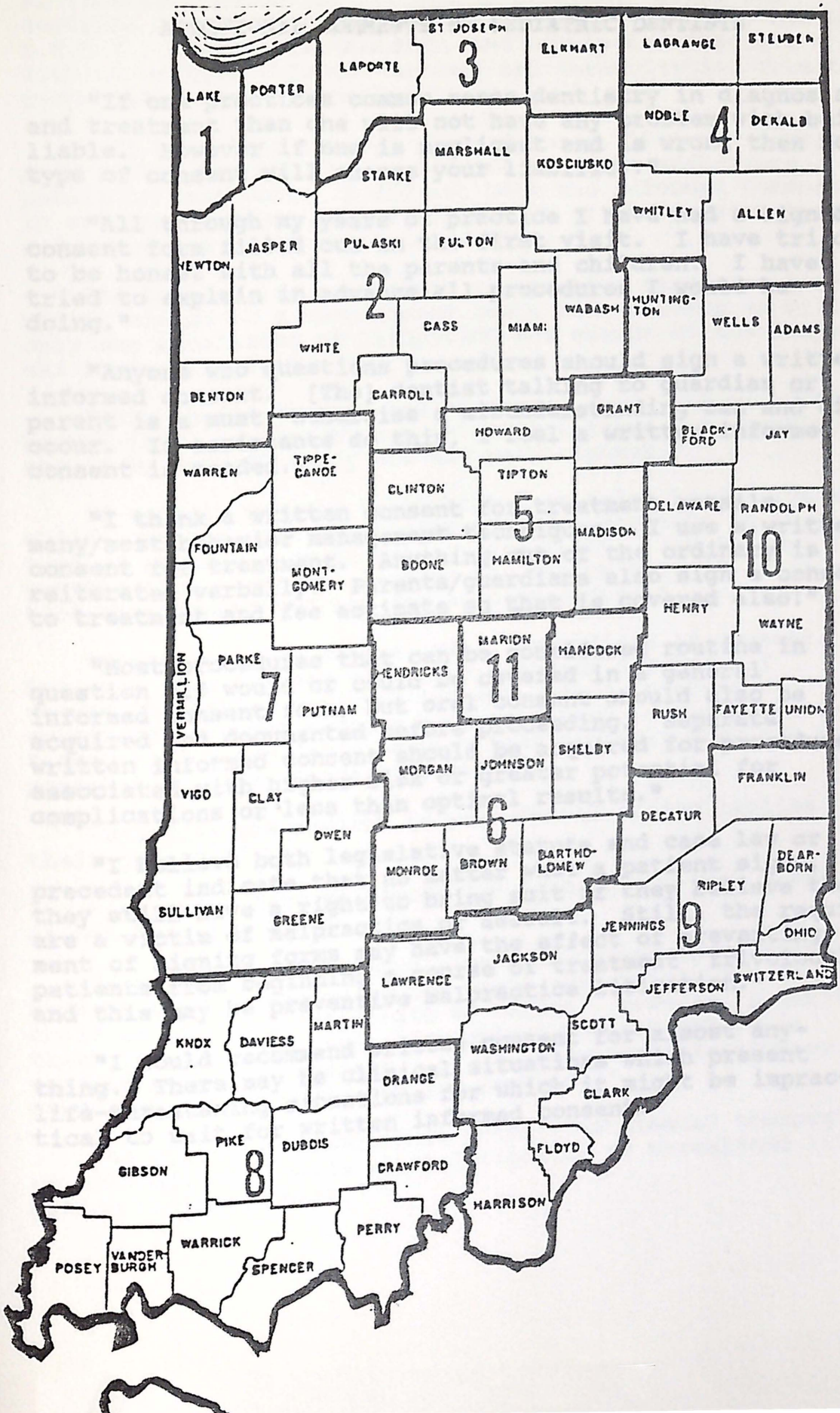
INDIANA STATE BAR ASSOCIATION

Approximate Membership

Indiana State Bar Association	9,583
Indiana only	8,309
Bankruptcy and Creditors' Rights Section	254
Corporate Counsel Section	263
Corporation, Banking and Business Law Section	615
Criminal Justice Section	224
Family and Juvenile Law Section	313
General Practice Section	278
International Law Section	84
Labor and Employment Law Section	227
Governmental Practice Section	173
Management and Economics of Law Practice Section	96
Natural Resources Section	111
Patent, Trademark and Copyright Law Section	103
Probate, Trust and Real Property Section	919
Taxation Section	448
Trial Lawyers Section	731
Young Lawyers Section (36 and under)	2,176

District Breakdown (see attached map):

	Number	Trial Attorneys	% Trial Attorneys
District 1	675	58	8
District 2	482	44	6
District 3	657	58	8
District 4	671	58	8
District 5	565	54	7
District 6	570	51	7
District 7	484	44	6
District 8	512	44	6
District 9	396	37	5
District 10	374	29	4
District 11	2,937	257	35
		731	100


ST JOSEPH
3
ELKHART
LAGRANGE
STEUBEN
LAPORTE
LAKE
PORTER
1
NOBLE
4
DEKALB
MARSHALL
KOSCIUSKO
STARKE
WHITLEY
ALLEN
JASPER
PULASKI
FULTON
NEWTON
2
WABASH
HUNTING-
TON
WELLS
ADAMS
CASS
MIAMI
WHITE
BENTON
CARROLL
GRANT
HOWARD
BLACK-
FORD
JAY
TIPPE-
CANOE
WARREN
CLINTON
TIPTON
5
DELAWARE
RANDOLPH
MADISON
FOUNTAIN
MONT-
GOMERY
BOONE
HAMILTON
10
HENRY
WAYNE
MARION
11
HANCOCK
PARKE
7
HENDRICKS
VERMILLION
PUTNAM
RUSH
FAYETTE
UNION
SHELBY
MORGAN
JOHNSON
FRANKLIN
VIGO
CLAY
6
DECATUR
OWEN
MONROE
BROWN
BARTHO-
LOMEW
DEAR-
BORN
RIPLEY
SULLIVAN
GREENE
JENNINGS
9
OHIO
JACKSON
LAWRENCE
JEFFERSON
SWITZERLAND
KNOX
DAVIESS
MARTIN
SCOTT
WASHINGTON
ORANGE
CLARK
PIKE
8
DUBOIS
FLOYD
GIBSON
CRAWFORD
HARRISON
PERRY
WARRICK
POSEY
VANDER-
BURGH
SPENCER

APPENDIX 13

ADDITIONAL COMMENTS BY PEDIATRIC DENTISTS

"If one practices common sense dentistry in diagnosis and treatment then one will not have any problem with being liable. However if one is negligent and is wrong then no type of consent will change your liability."

"All through my years of practice I have had a signed consent form filled out on the first visit. I have tried to be honest with all the parents and children. I have tried to explain in advance all procedures I would be doing."

"Anyone who questions procedures should sign a written informed consent. [The] dentist talking to guardian or parent is a must, otherwise a misunderstanding can and will occur. If assistants do this, I feel a written informed consent is needed."

"I think a written consent for treatment entails many/most behavior management techniques. I use a written consent for treatment. Anything out of the ordinary is reiterated verbally. Parents/guardians also sign a consent to treatment and fee estimate so that is covered also!"

"Most procedures that can be considered routine in question #15 would or could be covered in a general informed consent form, but oral consent should also be acquired and documented before proceeding. Separate written informed consent should be acquired for procedures associated with higher risk or greater potential for complications or less than optimal results."

"I believe both legislative statute and case law or precedent indicate that no matter what a patient signs, they still have a right to bring suit if they believe they are a victim of malpractice or assault. Still, the requirement of signing forms may have the effect of preventing patients from beginning a course of treatment frivolously, and this may be preventive malpractice litigation."

"I would recommend written consent for almost anything. There may be clinical situations which present life-threatening situations for which it might be impractical to wait for written informed consent."

"Unless you have consent in writing, you will always be at risk in a potential litigation problem. Since the doctrine of [informed] consent has become an issue, use of H.O.M.E., restraints, H.O.M.E. and airway are obsolete without written informed consent and authorization from the responsible parent/guardian."

"[I] have been retired since October, 1986 and [during] most of the practice years did not have the suit-prone public to deal with. I did not have the informed consent in writing, but see that it is a must at the present time and would use it if still in practice."

"As long as lawyers accept prospective cases for liability claims on a contingency basis with clients we will only see escalation of litigation and awards to the lawyers and their clients!"

"This should be good and necessary study. I am pretty hacked in following through on consent forms. A summary should be sent to every one who participates."

"I usually explain everything I am going to do with a child from the type of management and restraints to the type of materials to be used on the teeth. The patient's parents sign a consent form on the health history at initial appointment but not for each procedure."

"Those who wish to sue, will, regardless of consent. But, the practitioner will have a better defense, if needed, by having informed consent. Also, process of obtaining informed consent by a competent, caring practitioner will establish a rapport that probably preclude the possibility of a malpractice suit."

"Bringing the patient to your dental office implies their consent!"

"It may be hard to always get consent, so just have to do the best you can."

"I think consent should always be gained and written consent that is signed by the party responsible for the child is the least difficult to refute. However, I don't think it will stop litigation unless the litigation is against a lack of consent. If an irresponsible attorney wants the money, he'll sue for anything!"

"As with most problems it doesn't get tested thoroughly on an individual basis until litigation or threatened litigation raises it head."

"People seem to be very alarmed at signing for routine care procedures."

"In certain situations it is conceivable that I would want a written informed consent for everything listed [question 15] - If I felt that way - I would rather not treat the patient if there was an ethical alternative.

"But conforming to the doctrine will have a favorable influence if litigation is encountered."

"I just don't believe the issue is without "grey" areas."

"Although, I have often spent over 20 minutes and occasionally over 1 hour, I sometimes fail to get consent with some of the "tough" cases and am unable to do what I've recommended."

"If the patient chooses to sue you they will do it in spite of your attempts. However, the court may recognize that you have made the attempt."

APPENDIX 14

ADDITIONAL COMMENTS BY TRIAL ATTORNEYS

"You should use a "general informed consent" release to cover many of the items contained on this list [question 15] and special ones for the more drastic procedures, e.g., root canals, crowns, etc."

"The underlying principle is simply that if there are risks to a particular procedure or to the failure to do a particular procedure, then those risks must realistically be conveyed to the patient or if the patient is a minor or otherwise legally incompetent, then to the legal guardian and/or parent of such person."

"If there is one rule with respect to informed consent that every physician or dentist should live by, it is this: to be aware of the risks and to intelligently inform the patient of those risks. It is the patient's right to decide whether he or she wants the treatment. In order to make an intelligent decision, the patient must be informed of those risks. It would also be my recommendation that if there is a risk and if the patient is advised, then the advice should be memorialized in written form which in fact spells out what the risks are and that the patient has been so advised and consents to the treatment."

"Question 15 covers a range of treatment from an "examination" to "treatment under general anesthetic." A simple "examination" under most circumstances offers few risks. It would be impractical to obtain a written informed consent from a patient for a simple examination in the absence of special facts which increase the risk. If such special facts exist, then written informed consent should be obtained. At the other extreme, however, written informed consent should always be obtained for "treatment under general anesthetic." Most of the treatments listed in question 15 should have written informed consent, because most of them have risks which should be explained."

"Again in summary, if any of the treatments listed in question 15 involve risks, they should be explained and an informed consent obtained. The specific applications of the general doctrine are rooted in "common sense" and in an appreciation of the principle that the patient has the right to decide what should be done to his or her body and further has the right to the technical information required to make an informed decision."

"In my opinion, [conforming to the doctrine of informed consent] reduces future malpractice litigation arising from lack of informed consent. I would remind you that only a small percentage of malpractice cases arise from the lack of informed consent without some further complicating questionable treatment. However, I do believe that obtaining proper informed consent does tend to reduce even malpractice cases that do not arise solely from lack of informed consent. This is because the patient has been realistically assessed of the possibility of a bad result and does not, therefore, assume a bad result is necessarily the result of negligence. One other factor that should be carefully considered by a physician or dentist is that communication with the patient whether before, during, or after treatment is the single most important deterrent to the filing of a medical malpractice action. There are a number of cases in which we are contacted by potential plaintiffs to review their medical treatment. On those occasions when after our review we find no basis for legal action, we explain to the clients why there is no basis. In most such cases, the clients accept our conclusions and are relieved that someone has finally explained the circumstances surrounding the treatment to them. In those cases, we are truly doing the physician's or dentist's job. The patient/client would never have been in our office but for the failure of the physician or dentist to communicate."

"The regular use of informed consent forms is good preventative medicine - there are no down side risks, only upside potentials."

"Good communications skills and patient relations coupled with proper legal form for informed consent are critical."

"But it [conforming to the doctrine of informed consent] will protect the dentist from liability when no informed consent is sought and then complications arise during or following the procedure."

"The [dental] schooling may adequately address the issue but actual practice leaves much to be desired (after the student enters private or group practice)."

"Common sense is the best defense to malpractice claims. Informing a minor's parents of serious surgical or potentially dangerous situations is always a good idea, as well as a professional approach to your practice."

"Since the Indiana informed consent law only requires that the practitioner advise of risks which his profession advises of, you (the pediatric dentists) can set your own standard - you don't have to inform one of risks or provide information which a reasonable person would need to make a judgement."

"[Written informed consent is needed with] any treatment of which any risk of complications exist."

"I have defended several dentists in malpractice suits and informed consent has come up as an issue in extraction and root canal therapy cases. Dentists definitely need to be more aware of their duties in this area."

"Informed consent is an example of how a legal doctrine has led to new absurd behavior by those in society affected by the doctrine, namely health care providers. The idea of requiring a written informed consent to perform a simple dental examination is ridiculous. However, if I was to counsel a dentist on all precautions available to limit liability requiring such written consent would have to be suggested. If I were counseling a dentist I would recommend a flexible system where the more complex the procedure the move formal the type of consent which would be obtained."

"To some degree informed consent produces more malpractice litigation because it makes the patient aware of his or her rights, however, it does reduce the likelihood of success of a malpractice action."

"Under Indiana law, a minor cannot enter into a contract for services."

"Full information - discussions - honesty help reduce malpractice."

"It seems too often that in the interests of volume business, dentists and physicians are unwilling to take the appropriate time to treat the patient as an understanding, capable person. The mouth, as any other part of that person's body is just that, his/her body and including the individual in a greater understanding of the procedure, risk, result, etc. would help create a less litigious society."

"I have not heard of the "doctrine of informed consent" and I am more inclined to think that this is a term used around law schools rather than out in the practice of law."

"While I am quite familiar with the doctrine of informed consent, it is difficult for me to comment on this

doctrine as it would relate to the field of pediatric dentistry for several reasons. The most important reason is that dentists generally have an extremely low exposure rate to malpractice claims and, secondly, would become involved in situations requiring informed consent very rarely. I would be surprised if there were very many lawyers who have been involved in an informed consent case with any dentist, and particularly a pediatric dentist."

"Informed consent is a very simple concept that I think gets blown considerably out of proportion. The first and most important element is that the patient consent to the procedure, and secondly, that his consent be knowing. As a practical matter, informed consent is almost never a problem until the result is something that the patient did not expect. A simple guideline to follow is that the necessity in terms of detail, content and documentation increases as the risk of the procedure increases."

"...the incidence of medical negligence claims against dentists generally should be low. The cost of prosecuting claims against health care providers is such that it is generally not economically feasible to prosecute claims against dentists. Excluding the use of general anesthesia, there is not much that a dentist can do in the general practice of dentistry that can cause serious harm."

"However, obtaining such [informed] consent from the parent or guardian will not necessarily (indeed probably does not) relieve the dentist of obtaining informed consent from the minor as well."

"Obtaining an informed consent may or may not reduce the amount of litigation, but it ought to reduce the instances when liability is found."

"Oral informed consent is effective; written informed consent is preferable because of a record which avoids differences in recollection between doctor and patients."

"I don't know what is taught in dental school, but common sense is a beginning."

"Your questions are wrong to the point of non-sensical when addressed to a lawyer. We know nothing of your training except as it may apply to an actual case."

"Informed (written) consent is never a replacement for good practice and adequate peer review."

"Written informed consent to me means documentation (and signature) of the giving of oral informed consent.

For example, I wouldn't advise putting in writing every risk, no matter how remote. Nor would I advise listing the patient's condition, expected outcome in detail, all alternatives to proposed treatment, etc. You would wind up trying to condense years of dental school training onto 8 1/2"x11" sheets of paper. And undoubtedly forget something. What I would advise is a short summary of the proposed treatment and the major risks. I would also advise putting a disclaimer of guarantee as to result and the following:

> My dentist has explained my child's condition, the proposed treatment, its risks and expected outcome as well as the alternatives available. He also answered any questions I have and I authorize and consent to treatment. See, I.C. 16-9.5-1-4(c).

"Read Indiana's new Health Care Consent Law at 2C 16-8-12-1 et seq."

"The problem you will run into is balancing documented disclosure with teaching dentistry as well as scaring patients out of your office. Resolution of the problem will center on judgement: your judgement as a health care professional and your lawyer's legal opinion (I happened to be reviewing a hospital - client's consent form when my partner asked me if I would respond to your survey)."

"I don't think most trial lawyers know what "pediatric dentistry" practices are, let alone what is taught to those who practice it regarding consent - informed or otherwise."

"I fail to see what possible value the opinions of attorneys can hold for you. The jury, after hearing testimony from experts, and using common sense, determine whether a defendent's conduct is reasonable. You won't find attorneys on juries."

"Informed consent is vastly overrated as a theory in malpractice litigation. The standard of proof and the essential elements pose a tremendous burden for a potential plaintiff. In the last 8 years I have been heavily engaged in medical malpractice defense litigation. I not only have never seen a good case based on lack of informed consent, I have never even heard of one."

"It would seem that a general informed consent form (written) should be obtained from the patient's parents or guardian on initial visit. That should suffice for routine treatment. Any unusual costs should be protected by an informed consent and costs above a certain figure by a written consent."

"Written informed consent can reduce but not eliminate litigation."

"Most practitioners feel that explaining the procedure and potential risks is sufficient for informed consent. However, the law requires that the patient, (or in this case the parent or guardian) must understand the information. Also, many practitioners fail to inform the patient of alternatives to the planned treatment, and what might happen if the patient refuses the recommended treatment. If a practitioner sees many patients for a particular procedure which requires informed consent, it is preferable to have a "check list" form which is signed by the parent or guardian and maintained in the patient's chart. This is preferable from a legal standpoint since much time may elapse (particularly in the case of a minor under the age of 8 years old) before a malpractice action is ever tried, and patients and/or parents universally forget what is told them."

"[In response to question 16] not actual filing of claim perhaps, but certainly makes defense of claim much easier if is documented in chart and signed consent form."

"I don't believe that an attorney really understands the problems relative to informed consent as it relates to dentists. It would depend on the facts of a particular case. One can overemphasize the legalities of treatment. It should probably be related to the treatment risks involved."

"I believe that the people who see attorneys are the ones who have requested an explanation relative to some misunderstanding and have been brushed off by the professional."

"The doctrine only gives the patient the necessary information to evaluate the risk of the procedure and submit to the physical event. The doctor still has to properly conduct the treatment. Informed consent violation[s] are not really prosecuted in Indiana in civil court suits. The patients in this state need informed consent, not the doctors or lawyers. Informed consents builds and cements the doctor/patient relationship. Good communication and confidence is the best defense to a potential suit."

"It is necessary for all professionals to exercise every possible precaution to avoid malpractice litigation. Large verdicts have created a desire to recover easy money. As a result, many malpractice cases, without any merit whatsoever, have been filed. It is so important, in

the defense of a malpractice case, to have supporting record evidence. Dentists and all other professional should recognize the necessity of keeping adequate, complete records."

"If at all possible written informed consent should be obtained. In emergency situations where it cannot, the nature of the emergency and the effort to obtain the consent should be made of record."

"Always try and obtain written consent. If you cannot obtain written consent, then try verbal...if you cannot obtain either, then make a record of the efforts and the nature of the emergency."

"I believe any doctor who does not obtain written informed consent is asking for a malpractice action. Ninety-nine percent of all cases require it."

"Establish the habit - do it [obtain written informed consent] everytime!"

"But it [conforming to the doctrine of informed consent] does help the defense of such claims."

"Give informed consent for all treatments having a risks of harm to the patient."

"[Conforming to the doctrine of informed consent reduces or eliminates malpractice litigation] because it makes available a defense not otherwise available and cases may not be filed. Secondly, the giving of consent does away with some of the causes of action."

"Most dentists do not allow the parent in the room with the dentist and their child, so dentists need to take extra time with parents to explain what's been done, etc."

"A general consent taken at the outset of the relationship should be sufficient to inform the patient of routine procedures and obtain consent. More serious procedures should be specifically discussed each time."

"We do not see many medical malpractice cases involving pediatric dentistry and the issue of informed consent."

"A comprehensive form could be constructed, read and signed by parent and mature child."

"As a rule, keeping a paper record of having obtained informed consents is good practice as it reduces malpractice exposure and probably makes a patient more cooperative."

"Unless there is a record, the informed consent issue is reduced to a witness v. witness credibility fight. The more complete the record and the more involvement of the patient (or parent) in creations or verification of the record, the less there will be of a witness v. witness credibility fight."

"[The use of oral informed consent together with an informed consent form] should be given far enough ahead of treatment that the patient can consider it."

"Each of the "Written Informed Consent" choices above [question 15] may prove somewhat burdensome to the dentist and his/her staff, and may cause hesitancy by patients, but I believe it to be best from the dentist's malpractice perspective."

"[Pediatric dentists are more concerned with obtaining informed consent today than they were in the past] but generally for there own protection rather than to protect the interests of their patients."

"Dentists should be taught the most important thing a dentist can do to prevent a claim is to establish a good relationship with the patient, patiently explaining all procedures and taking time to discuss the patient's concerns and answer questions."

"It has become a very "tough world" for professional persons. Although far from being 100 percent effective, consent forms will help some and every profession needs all the help possible."

"Obviously, the informed consent of the parent(s) or guardian or person having legal custody of a minor patient should be obtained:

a. where the dental procedure is life-threatening;
b. where major surgery is involved;
c. where medications are involved which are unusual or which may trigger allergic side effects; and,
d. any procedures which involve other than preventive dentistry or routine checkups."

"...the wave of malpractice litigation compels dentists, as well as other health care providers, to practice "defensively," involving more paperwork and greater cost to the patient."

"I congratulate you upon undertaking your thesis on this particular subject matter, and wish you well in the survey results/interpretation."

"If my wife would have been advised of the possibility of nerve damage when she had a wisdom tooth removed in a non-necessary operation, we would not have had it [the surgery]."

"I do not think the question is a reduction of malpractice litigation. I think it is a question of patient care. Informed consent is designed to give the patient all of the facts so that he can decide non-essential cases. That's the goal of informed consent."

"Written informed consent should specify all possible risks and possible side effects of procedure."

"Get the best consent you can under the circumstances."

"In some 20 years of malpractice defense work, I have never had or even heard of a case where a pediatric dentist was sued for lack of informed consent."

"Most "informed consent" cases stem from a bad or unanticipated result. Even if the patient was properly informed, many feel bad or [that the] unanticipated outcome must have been caused by lack of proper care. Few cases are filed based solely on a lack of informed consent. I think it's very difficult for a patient to make a case of informed consent because the physician or dentist is halfway competent, the patient probably would have been worse off without the procedure than he is from the damage caused by the procedure. Informed consent is a "big" legal issue but in practice it's not that big of a deal in my opinion. A patient who tries a case on informed consent alone hasn't got much of a case even if the physician or the dentist told him nothing."

"Informed consent, is an excellent idea in any profession, but when it gets down to who wins or who loses, one had better have more evidence of negligence than just informed consent."

"[Conforming to the doctrine of informed consent] eliminates the informed consent issue. It does not eliminate litigation regarding quality of care."

"As a plaintiff's attorney reviewing a medical/dental malpractice claim, one of the first things I look for is a written, signed consent. Next I look for a chart notation of an oral informed consent. The dentist should always err

on the side of being able to demonstrate (by a document) that informed consent was given. Without a written consent, the dentist puts his/her credibility at issue with the patient's credibility."

"Patient[s] cannot knowingly consent to treatment without knowledge of the dangers. If more patients received more information about their treatment, they would not be so surprised when things went wrong; therefore, they would be less likely to sue or undergo the treatment. The physicians and dentists have no right to play God and decide how one should decide on treatment."

"The dentist has the duty to make reasonable disclosure of material facts relevant to a decision which parents are required to make. The dentist must show consent to course of treatment as a defense: therefore, always get informed consent in writing (at least a standardized consent form) which acknowledge or advise the parents and the children over 14-15 years of age of associated risk(s). [This is the] only way the dentist can effectively prove what was said and that consent was given."

"The fact of the written consent will deter many claims and will permit defense of others. Therefore, do [get a written informed consent]! [The written informed consent] must be reasonably current and must be reasonably specific."

"If there is no causal relationship between failure to inform and injury to patient, there is no proximate cause if plaintiff would have had treatment even if full disclosure made!"

"[Conforming to the doctrine of informed consent does not reduce or eliminate future malpractice litigation] but it reduces the likelihood of the dentist losing the case."

CURRICULUM VITAE

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Professional Organizations

American Academy of Pediatric Dentistry
American Association for Dental Research, Indiana Section
American Association of Dental Schools
American Dental Association
American Society of Dentistry for Children
Board Eligible, American Board of Pediatric Dentistry
Delta Sigma Delta Dental Fraternity
Indiana Dental Association
Indiana University Pediatric Dentistry Alumni Association
Indiana Society of Dentistry for Children
Indiana Society of Pediatric Dentistry
International Association for Dental Research
Massachusetts Dental Society

ABSTRACT

INFORMED CONSENT: A COMPARATIVE STUDY OF ATTITUDES AMONG PEDIATRIC DENTISTS AND TRIAL ATTORNEYS IN INDIANA

by

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Malpractice litigation is on the increase and a lack of informed consent is more frequently becoming primary and secondary causes of action. A study was designed to compare and analyze the viewpoints of Indiana pediatric dentists and trial attorneys concerning the doctrine of informed consent. The ultimate goal was to share the information with both groups and raise the level of awareness of the doctrine among pediatric dentists.

A three-page questionnaire dealing with the doctrine of informed consent was mailed to 85 pediatric dentists and 350 trial attorneys practicing in Indiana. The response rate for pediatric dentists was 70.6 percent and the response rate for trial attorneys was 61.4 percent.

Overall, most pediatric dentists and trial attorneys were moderately familiar with the doctrine of informed consent. However, trial attorneys do not feel that pediatric dentists conform to the doctrine, while pediatric dentists perceive that they do conform. Pediatric dentists and trial attorneys recommend that informed consent be obtained orally and then documented on an informed consent form. Both professional groups agree that obtaining informed consent is necessary in the practice of pediatric dentistry. Unfortunately, pediatric dentists and trial attorneys do not feel that predoctoral dental school education or specialty training prepares the pediatric dentist to obtain an informed consent.

Not surprisingly, both groups feel that pediatric dentists are more concerned with obtaining informed consent today than they were in the past. Most pediatric dentists are obtaining informed consent in less than five minutes. However, pediatric dentists feel that the time spent obtaining informed consent has either remained the same (55.9 percent) or increased (44.1 percent); trial attorneys feel that this trend has increased (81.5 percent). Overall, pediatric dentists and trial attorneys disagree on whether parental consent is required for specific patient types. Moreover, the two groups agree on the type of consent necessary for 20 dental procedures (54 percent) and disagree on 17 dental procedures (46 percent). Finally, most trial

attorneys and pediatric dentists feel that conforming to the doctrine of informed consent reduces or eliminates future malpractice litigation.