LITIGATION, LEGISLATION, AND ETHICS

Informed consent and the fourth dimension

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How many times has this happened to you? An adult patient presents for an initial evaluation. You determine that there is a significant skeletal component to her Class II Division I malocclusion. You dutifully do your informed consent thing, going over the various treatment options, etc, and the patient tentatively agrees that the best chance to achieve an ideal result is orthodontic treatment combined with mandibular advancement. You know your stuff, so you're going to decompensate the case, making the malocclusion worse in order to maximize the surgical result. So far, so good. About 8 months into treatment, your patient balks; she has second thoughts about the surgery, and says that she has changed her mind; she now wants you to finish treatment using orthodontics only. You try to educate her as to the error of her ways but she is adamant. At this point do you have to do a whole new informed consent consultation attendant to a nonsurgical camouflaged approach, even though you did this comprehensively prior to treatment? *Schreiber v. Physicians Insurance Company of Wisconsin*, 588 N.W. 2d 26 (1999) says you do.

Schreiber was an obstetrics case gone bad, but the legal theory is applicable to orthodontics. The trial court held that the defendant doctor was under no obligation to re-advise the plaintiff of her options or the risks inherent in her new choice of treatment because they were the same midtreatment as they were originally. Since there was no change in the patient's medical condition and no change in the risks or information to be balanced, a new informed consent discussion wasn't needed merely because the patient changed her mind and chose to undergo one course of therapy as opposed to another.

The appeals court reversed, holding that "where two or more medically acceptable options for treatment are present, the competent patient has the absolute right to select from among those treatment options after being informed of the relative risks and benefits of each approach." (cit. omit.)

The Wisconsin Supreme Court, in reviewing this matter, first outlined in detail the issues they were deciding. The informed consent issue was this: does the midtreatment withdrawal of a patient's consent, coupled with the existence of other viable treatment alternatives, trigger a duty to hold a new informed consent discussion with the patient concerning the risks and benefits of the available options, even though they were discussed at the initiation of treatment? Wisconsin, like a majority of states holds that "a physician's duty to reveal the risks and benefits of available treatment options extend[s] to the information a reasonable patient would need to know in order to make an informed decision." The court was also quick to add that, in addition, "physicians [are] not required to disclose absolutely every fact or remote possibility that could theoretically accompany a procedure." This was codified in Wis. Stat. 428 Sec. 448.30, which states:

> *Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of those treatments. The physician's duty to inform does not require disclosure of: (1) information beyond what a reasonably well-qualified physician in a similar medical classification would know, (2) detailed technical information that in all probability a patient would not understand, (3) risks apparent or known to the patient, (4) extremely remote possibilities that might falsely or detrimentally alarm the patient, (5) information in emergencies where failure to provide treatment would be more harmful to the patient than treatment, (6) information in cases where the patient is incapable of consenting.*

The court went on to note that because patients have a right to refuse treatment, they also have the right to change their minds about continuing with a course of treatment which, in effect, withdraws their consent for the original treatment. The court continued by noting that at some point in time, in virtually every form of medical treatment, there is a point from which there is no return; however, the court was quick to point out that this point in time need not be specified at the beginning of treatment. Rather, it should fit the nature and circumstances of each procedure and continue so long as other viable treatment options exist. Quoting a Colorado decision, the court noted, "where a new, previously undisclosed, and substantial risk arises, there may be an additional and independent duty to warn the patient of that risk." (cit. omit.)

Summarizing their position on this matter the court stated:

> *We decline to view the informed consent discussion as a solitary blanketing event, a point on a timeline after which such discussions are no longer needed because they are 'covered' by some articulable occurrence in the past. Rather, a substantial change in circumstances requires a new informed consent discussion. To conclude otherwise would allow a solitary informed consent discussion to immunize a physician for any and all subsequent treatment of that patient.*

The court also went to great lengths to point out that its decision should not be construed to mean that patients have a

0889-5406/2000/$12.00 + 0 **8/1/110888**
doi:10.1067/mod.2000.110888

right to demand any treatment that they desire, and noted that its opinion does not require doctors to perform procedures that they do not consider medically viable, procedures for which they lack the requisite expertise, or procedures to which they are morally, ethically, or professionally opposed. The case was remanded to the trial court to determine whether the lack of informed consent was the proximate cause of the injuries sustained.

COMMENTARY

So, one of your patients does not want teeth removed to resolve crowding. Another wants you to proceed without the pretreatment periodontal therapy you believe is needed. Still another does not want to have mesoangular canines exposed. Do you have to accept these patients for treatment on their terms? The answer is: NO.

What about the patient in our initial scenario, the one who got surgical cold feet? If we blindly proceed with the initial treatment plan, are we protected from litigation because we discussed these matters at our initial informed consent discussion? If this is your approach, think twice.

Too many practitioners make the mistake of believing that because the benefits and risks of treatment were discussed at the inception of treatment, they no longer need to address individual risks or benefits as they arise. Merely because an informed consent form was signed at the beginning of treatment does not mean that we are forever protected should negative sequelae occur midtreatment. The *Schreiber* case shows us that when the you-know-what hits the fan, and as long as other viable treatment alternatives are available, the decision as to which road to take belongs to the patients—and their roadmap is ongoing informed consent.

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