

# Behavior Management Conference Panel III Report—Legal Issues Associated With Managing Children’s Behavior in the Dental Office

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## Abstract

Panel III reviewed the legal issues associated with managing child behavior in the dental setting. The first issue addressed was a review of the recent changes in informed consent for behavior management techniques in pediatric dentistry. Discussions focused on: (1) who should obtain informed consent; (2) who can give informed consent; and (3) what constitutes appropriate documentation. Recent legal actions related to poor outcomes and poor communication using behavior management techniques were identified and discussed. Addressed was the current movement by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) towards empowering the child-patient to be a co-decision maker at all appointments and its impact on decisions in the dental office about approaches to behavior management. Finally, liability issues accompanying increased use of sedation in the dental office were identified and discussed. The recommendations of the panel were: (1) consideration should be given to changing the language in the current American Academy of Pediatric Dentistry (AAPD) guidelines, so written consent is not required for any procedure; (2) the AAPD should create language for use in creating sample consent forms (suggestive, not prescriptive); (3) guidelines recommending the possibility of treatment deferral, when appropriate, should be strengthened; and (4) the AAPD should work with advanced education program directors to standardize the quality and number of educational experiences in the use of conscious sedation. (*Pediatr Dent.* 2004;26:175-179)

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Panel III reviewed the legal issues associated with managing child behavior in the dental setting. The panelists were asked to address the:

1. legal issues impacting how dentists communicate with parents and children, with special emphasis on informed consent; and
2. choices dentists make about which behavior management modalities they use, including sedation and general anesthesia.

## What changes have occurred in pediatric dentistry regarding informed consent issues?

During the 1970s, there was a major transformation in the relationship between health care providers and their patients regarding consent for treatment. Prior to these changes, it was sufficient if the patient signed a simple agreement to be treated. Subsequently, during the 1970s, the professional community standard came into place. The professional community standard required a practitioner

to give a patient the pretreatment information a reasonable practitioner in the same community would give prior to treatment.

However, further changes during the 1970s ushered in the reasonable patient standard for informed consent. This standard requires a practitioner to satisfy the “informational needs of the average, reasonable patient rather than the professional community standard.”<sup>1</sup>

The new standard stated that a practitioner may be held liable if a patient or parent has not received all the information material to their decision to accept or reject treatment.<sup>2</sup> It represented a change from a paternalistic system, to one nearly unique to the United States, and different than most of the rest of the world. It also represents the ultimate in patient empowerment, begging the question, “Do patients have the information they want or need to know before giving consent?” This change was a classical common law development—not a federal legislative mandate. As a result, one now must explain procedures and potential risks, benefits, and consequences in much greater detail.

#### **Obtaining informed consent**

The panel recommended that, in general, the practitioner should not delegate to someone else the process of obtaining informed consent. People do not generally sue only because of mistakes, but rather because they are angry about why something happened. Therefore, clear communication between the practitioner and the parent/patient is an extremely important aspect of informed consent and the practitioner/patient relationship. The focus should be on the quality of and concern for the relationship and not just on the bureaucratic process of obtaining informed consent. In some cases, the practitioner may elect to assign this important duty to a well-trained member of the staff who may have more time to ensure that the process of obtaining consent from a patient is thoroughly and compassionately done.

#### **Appropriate documentation**

The panel suggested that the practitioner should add his/her own note about the parent’s comprehension of and agreement to the informed consent. A practitioner’s signature witnessing the signing of the informed consent alone is not enough. A note such as “parents seem to understand and agree and have few questions” is a good idea. Everything meaningful should be documented, and there must be enough content to refresh a dentist’s memory on the witness stand, if necessary, which is a practitioner’s right. The panel opined that keeping good and thorough records is one’s best chance to demonstrate to a jury that proper procedure was followed.

Audience members wanted to know whether certain procedures require specific written consent vs oral consent with documentation, and whether state laws determine the type of consent required. A panelist suggested that consultation with attorneys in the practitioner’s state would best

answer these questions. Obtaining written consent when not required might be exceeding the standards of the state, but it might be warranted in certain circumstances.

#### **Informed consent authority**

Determining who has the signing authority to give informed consent for procedures has become an increasingly complex issue, as many nonlegal guardians bring children to dental appointments. Even though it can be time consuming and difficult to determine who has legal authority to sign, for his/her own protection the practitioner must know who has this right. One practitioner panelist requires information about family status and who the legal guardian is on an office form. It may also be appropriate to ask for a copy of the court order regarding custody or legal guardian status.

The audience asked about people who may be providing false information about their identities and what the practitioner’s liability would be if he/she accepted their word. A panel member indicated that, if the practitioner had no reason to believe a person was lying, the practitioner could rely on good faith. Some practitioners said they fax treatment plans to both parents when they are separated or divorced.

The issue was raised of how to obtain informed consent in the case of foster parents. State law varies: some states allow foster parents to give consent while others do not. A panelist warned that the practitioner should be clear about the source of authority to consent (parents, if there is no dispute about custody; legal guardians or foster parents under some but not all state laws or courts) and remember that types of custody vary. Consulting a knowledgeable local lawyer familiar with jurisdictional requirements in the area was recommended.

An important point made by a panelist was that consent can be withdrawn by the parent during treatment and the practitioner must comply. The example given was of a parent in the waiting room who heard her child crying behind closed doors and asked the office personnel to stop treatment. It is important to understand that, at this point, the parent had withdrawn consent for treatment and the practitioner was required to stop the procedure in progress, after doing only the immediately necessary steps to bring the procedure to a safe conclusion.

An audience member asked how to deal with people who say they did not understand what they signed. A panelist answered that people can always argue they did not understand—but that does not mean they will win the lawsuit.

#### **Informed consent from non-English-speaking parents/guardians**

Translation services are available for obtaining informed consent from non-English-speaking parents/guardians. For instance, Atlanta offers a licensed translator hotline,

available for a fee. The practitioner would have to pay the fee but could then bill the patient for the fee.

#### More specific informed consent forms

Informed consent forms should include the procedures, risks, and benefits. A panelist emphasized that consent is communication and a process. The form itself is not as important as communicating what the practitioner is preparing to do. The forms should include language appropriate for a sixth- or eighth-grader. It may be advisable to have a local attorney review the form's language. Several audience members requested the AAPD develop standardized consent forms that could be used and adapted by practitioners.

An audience member noted malpractice insurance companies can ask practitioners to have informed consent forms for specific procedures such as local anesthesia. This is not normally considered a procedure requiring separate consent. A panelist suggested that if insurance companies became too burdensome in their requirements, it might be necessary to involve health care lawyers to engage the insurance industry on one's behalf.

#### Dealing with unrealistic parental expectations

Dentists cannot guarantee pain- or discomfort-free treatment. Even though no litmus test exists to indicate which parents will be troublesome, one can gather many cues from parents as to how receptive they will be to various behavior management techniques. Informed consent is also designed to put boundaries in place for the parents' and childrens' expectations—and for parents to share responsibility in the care of children.

#### AAPD's informed consent guidelines

The American Academy of Pediatric Dentistry (AAPD) Clinical Guideline on Behavior Management<sup>4</sup> says that informed consent must be obtained and should be documented for behavioral methods. In the 2000 revision, "written" was inserted as a modifier for consent for some behavior management procedures. A panelist suggested the law only requires obtaining informed consent. Documenting the informed consent process can be done using several different methods.<sup>3</sup> To hold our members to only one method when another is acceptable places them in a vulnerable position.

One panelist noted that, according to an AAPD disclaimer, the guidelines<sup>4</sup> are not standards of care, even though they are being interpreted by many entities as standards. In response, another panelist noted standards of care might be more likely to create liability than protect one from it. He recommended asking the question, "Are we ready to be bound by these rules we are about to make?" Guidelines could be viewed as mandatory, even though they are meant to be suggestive.

### What legal actions have been taken due to poor communication and outcomes using behavior management techniques?

Examples were provided of 2 dental board cases from Wisconsin since 1996:

1. failure to get consent to use the hand-over-mouth exercise (HOME), resulting in a \$250 fine; and
2. failure to obtain informed consent for restraint, resulting in a \$250 fine and an order to complete a continuing education course.

In addition, under peer review, some cases have been brought forth based on perceived lack of communication with the parent or because another practitioner was involved who "flamed the fire" with the patient.

A question was asked about implied consent when a parent is present in the operatory, witnesses the behavior management procedure being performed, does not object or interfere, and later returns with legal action against the dentist for the procedure. It was the panel's opinion that the dentist would probably prevail, as there is an argument about waiving the right to object. However, it would be better if the dentist had material in writing about behavior management techniques used in the office. One panelist described such an experience with a parent, but had obtained consent prior to the procedure later called into question.

Another panelist identified some California cases concerning 1 practitioner with 14 counts against him for using restraints. The practitioner had misrepresented the restraints in the informed consent document as "soft blankies" when, in fact, he had tied the children's hands down with belts. The issue here is one of honest representation in the informed consent of the procedures to be performed.

What kinds of actions by practitioners warrant criminal charges? When criminal charges are brought against a dentist, they are not covered by malpractice insurance, and his/her practice can be at risk. One panelist summarized a Texas case in which a dentist was convicted of involuntary manslaughter with a deadly weapon of a patient in his care and was sentenced to 5 years in prison. However, this case involved gross judgment errors by the dentist. In the past, the dentist had numerous "close calls," failed to heed warnings by the pharmaceutical representative for prior overdosing of patients, and ignored warnings of a serious impending outcome in the patient fatality case. The panel agreed a dentist has to be extremely reckless to be found criminally liable.

If or when a dentist decides to ask a parent to leave the practice, does the issue of abandonment come into play? The panel opined that it is appropriate to ask a parent to leave the practice when a practitioner determines the "fit" is not good. At that time, it is also wise to refer the patient to another dentist. The referral should be made with tact, dignity, and compassion, to whatever extent possible.

## **What is the impact of the current JCAHO drift towards empowering child patients to be codecision makers at all appointments and at what age is it necessary to obtain a child/adolescent's assent/consent for behavior management techniques and treatment?**

Consent is binding; assent is not. Obtaining assent is a well-intentioned effort to involve children in health care decisions and help them mature in their ability to do so. The panel agreed obtaining assent is a good practice, but not legally binding. The age of assent varies, and several members of the panel reported the ages for the IRB assent statements at their institutions varied from ages 7 to 8.

One panelist brought up a hypothetical example of a 12-year-old patient who objects to being treated, even though the practitioner has the parent's consent to treat. In this example, the panel agreed the practitioner needs to work closely with the parent, as it is the parent's job to get the child to comply with the procedure for which consent was granted. Good patient management techniques dictate that the practitioner listen to these older patients, give them knowledge, answer questions, and gain trust—even though they will not solely make the decision. Engaging the patient in treatment plan discussion is effective and helps make him/her feel more in control of the experience, even though the parent makes the final decision.

## **What liability issues accompany increased use of sedation in the office?**

The panel believed that if a practitioner has an emergency associated with sedation in his/her office today, calling 911 alone is not enough. The expectation for practitioners who use sedation is that he/she must be able to "rescue" the patient. This requires in-depth training in sedation use and the recovery of sedated patients. Many states today require practitioners to be credentialed in administering conscious sedation. An audience member reported that a Kansas-based sedation committee writing sedation regulations faces the dilemma of how to certify training for the use of sedation. The committee is currently accepting graduation from an accredited advanced education program with training in sedation and anesthesia.

However, the committee knows there is much variation among pediatric dentistry programs in the amount and level of training and experience in the use of conscious sedation. AAPD postgraduate program directors are discussing how to improve the standardization of their teaching in conscious sedation. In addition, the AAPD has developed a state-of-the-art course in conscious sedation currently being offered at various continuing education venues. Panelists noted there has not been a single case of adverse outcomes when AAPD guidelines for conscious sedation were followed.

The following unanswered questions were raised by the audience:

1. Who is responsible for monitoring whether practitioners follow sedation guidelines?
2. Why is death the sentinel event that triggers oversight?
3. Could we not start earlier?

As a solution to sedation concerns, one audience member suggested simply deferring treatment. When dentists are not able to treat a child due to poor behavior, they can postpone treatment until the child is older and possibly better able to behave. This is called "selective deferral," and it should appear somewhere in the AAPD guidelines. A panelist noted this concept is referenced in the guidelines, with the parents' consent, but it is not readily apparent and should be highlighted to a greater extent.

Dental anesthesiologists are now providing services in pediatric dental offices in various parts of the country and are performing deep sedations for the types of patients who might otherwise require general anesthesia. The requirements for the pediatric dentist in whose office the procedures are performed vary by state, and some require the practitioner to have a permit at the same level as the individual performing the anesthesia. There are AAPD guidelines for using dental anesthesiologists in dental offices. As this procedure becomes more common, more attention may need to be paid to the risks and credentialing requirements for pediatric dentists using dental anesthesiologists.

## **Recommendations**

1. Consideration should be given to changing the language of the AAPD Behavior Management Guideline to eliminate written consent for any procedure. At the same time, the panel emphasized written documentation of informed consent can be the most important protection a dentist has when faced with certain types of complaints or litigation.
2. AAPD should create sample consent forms (suggestive, not prescriptive/and guidelines for their use).
3. AAPD should strengthen the guidelines regarding treatment deferral, when appropriate.
4. AAPD should work with advanced education program directors to standardize the quality and number of educational experiences in conscious sedation, to produce graduates with uniform credentials in these techniques.

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