International Journal of Social Science And Human Research

ISSN(print): 2644-0679, ISSN(online): 2644-0695

Volume 06 Issue 02 February 2023

DOI: 10.47191/ijsshr/v6-i2-32, Impact factor- 5.871

Page No: 1007-1016

Informed Consent in Dental Practice: A Qualitative Analysis of Awareness and Apprehensions Among Practitioners in South India

Dr Baiju R M[1], Dr Elbe Peter[2], Dr Vivek Narayan[3], Dr Roshna E K[4], Dr Abhilash Babu[5], Dr Nandimath Omprakash V[6]

[1]Professor, Department of Periodontics, Government Dental College, Kottayam

[2]Professor and Head,Department of Orthodontics, Government Dental College, Thrissur

[3]Assistant Professor, Department of Public Health Dentistry, Government Dental College, Kottayam

[4]Senior Resident, Department of Periodontics, Government Dental College, Kottayam.

[5]Director, School of Social Sciences, Mahatma Gandhi University, Kottayam

[6]Professor of Law, National Law School of India University, Bangalore

ABSTRACT: Context: The push for autonomy and liberalization has transformed the practice of medicine and dentistry from paternalism to a patient cantered model. Patient's choice to accept or reject the proposed treatment is central to this new paradigm of health care. Informed consent is an essential tool for an ethical dental practice.

Aim: The objective of the present study was to explore the knowledge, attitudes, perceptions and prevailing practices among dentists regarding the informed consent process.

Materials and methods: A phenomenological approach was undertaken. A semi structured telephonic interview was conducted based on a flexible topic guide and continued until data saturation .

Statistical analysis: The data was transcribed verbatim. Coding and categorisation done. Anonymity was ensured in all steps.The data was subjected to a thematic analysis.

Results: Participants were apprehensive about the influence of social media on the new paradigm of doctor patient relationship and the increasing utility of specialists as a protection from litigation. Lack of clarity regarding the consent method has prevented its routine application.

Conclusions: It can be concluded that a comprehensive understanding regarding informed consent process was lacking among the participants.

KEYWORDS: consent, informed consent, autonomy, dental litigation

INTRODUCTION

In the last couple of decades, a better education made way for an improved awareness regarding health reemphasising the patient at the core of modern healthcare system across the world. The push for autonomy and liberalization has transformed the practice of medicine and dentistry from *paternalism* to a patient cantered model. Seamless bilateral communication, unconditional provision of health information and informed decision making are the key to the modern day doctor-patient relationship. Patient's choice to accept or reject the proposed treatment is central to this new paradigm of health care. Dental practice, although a part and parcel of modern medicine, is different from medical practice in that almost all patients require some procedure or intervention at some stage of management of their oral/dental problem.

Informed consent is an essential tool for an ethical dental practice. It is the systematic process of sharing of relevant information related to their health condition and treatment to enable them to make rational choices from multiple options[1]. Recent studies points to difference in awareness with respect to legal, ethical and regulatory aspects of dental care among dental practitioners [2,3].

Although dental ethics and jurisprudence is included in the syllabus in dental schools, there is insufficient information regarding the process of obtaining the informed consent.

The objective of the present study was to explore the knowledge, attitudes, perceptions and prevailing practices among dentists regarding the informed consent process in routine clinical practices.

METHODOLOGY

The ethical clearance was obtained from the Institutional Ethics Committee of (order no. IEC/M/22/2021/DCK dated 26/05/2021). A descriptive design using qualitative approach was followed in the study. The sample was drawn from registered dental practitioners in and around Kottayam, educationally progressive city in central Kerala, India. A purposive sampling approach was chosen. The objective was to include participants with a wide range of practice experience and academic qualification. Clinical practice experience ranged from beginners (less than one year) to more than 25 years and academic qualification ranged from graduate generalists to senior specialists including research guides.

Fourteen dentists including clinical practitioners running their own single doctor clinics, consultants of multispecialty corporate clinics and academic staff of dental colleges at various levels of their career took part. Prior information was provided regarding the study methods and the collection, storage and handling of personal data (including telephonic interview and voice recording) and signed consent was obtained from participants. All the interviews were conducted by the principal investigator based on a flexible topic guide that was piloted and validated by 3 experts, one experienced dental clinician, one dental expert with legal expertise and a social scientist. Three mock interviews have been conducted for piloting the entire process. Each interview was scheduled at a convenient time for the participants and lasted for 30 minutes to obtain rich and valid data. After each interview, necessary modifications were made in the topic guide before proceeding to the next session to obtain maximum relevant information. The interviewer had freedom to ask open-ended questions whenever necessary to bring out clarity in the expressions. Leading questions were avoided as it poses threat to validity. Before concluding each session, the subjects were given time to express their perceptions, expectations and concerns regarding the informed consent process. The telephonic interviews continued until no new theme arose based on data saturation approach. Audio recordings were later transcribed verbatim.

Thematic analysis was the approach followed in the analyses of data. The transcripts were read repeatedly several times for familiarization and open coding was performed using MS Word (Microsoft, Inc, USA). Themes were differentiated and over-arching themes were identified, and thematic charts were prepared after importing it into MS Excel spreadsheet (Microsoft, Inc, USA).

The interview guide was prepared to cover three major areas related to the topic under study 1) Doctor patient relationship- the changing paradigm 2) Current informed consent process: Ground reality and 3) Experience with dental litigation

OBSERVATIONS

Theme 1: Doctor - Patient relationship- the changing paradigm

Half a century ago, the health care sector was under developed and doctors were the sole care givers. Parallel with the industrial development, the health sector widened its scope with the addition of individual specialists, Para medical staff including nurses and pharmacists and presently a situation has come such that doctors are just a member of the health care team(3).

The doctor patient relationship is built on trust. However, in the last few decades considerable changes those have happened to the Indian health care sector resulting in a remarkable dip in this relationship of trust. Participants ranging from less than 1 to 33 years of experience, agreed unanimously that, the doctor patient relationship is entirely different compared to what it used to be in the past.

a. Influence of social media

The social media has invaded every aspect of human life, providing access to all sorts of information. All the respondents, unanimously agreed that social media has influenced the doctor patient interactions immensely. All of them opined that patients seek health information from internet and social media which has influence in their health related behaviour and decision making. Senior professionals, practicing prior to the social media age perceive this influence better and were more vocal about the transformation in patient's attitudes and behaviour. They opined that patients are well informed now regarding their health condition, and conscious about their choices and rights. Their expectations from the health care professionals have also increased unlike in the past making it difficult to satisfy them.

According to a respondent, a senior practicing academic:

"When I started my practice 25 years ago, by and large, patients used to accept and believe what you [doctor] suggest without any hesitation. Now they [patients] are much more aware about their health condition and its treatment, thanks to Google. Based on the information they got from the internet, they expect you [Doctors] to explain things until they get satisfied, and they compare you with the Google."

The information available at fingertips has empowered the patient. Blind trust on doctors as they know the best is now replaced with informed trust (3). The most senior clinician had the opinion that social media is damaging the traditional doctor patient relationship; whereas younger generation of professionals, recognize the potential of social media. One of the participants finds some advantage in patients getting prior information from internet regarding their health problem. She said:

"A good point is that, now you [dentists] don't have to explain how a root canal [treatment] is done with the help of pictures or drawings. You just suggest root canal [treatment] and they will know what it is and how it is [done].They are even aware of what complications a tooth extraction can bring about."

Younger practitioners are trying to utilize social media to their advantage, for self-promotion and practice development through campaigns and groups, reaching wider audience, show casing their skill through networking. Advantage of social media in fostering clinical practice was agreed upon by others also. Many see social media as an essential part of practice development. A young dentist opines:

"I get many patients through social media, through my fb [Facebook] and insta [instagram] accounts. My clinic has a web site which has provision for booking appointments. I think the social media is an integral part of my clinical practice'.

b. Increasing patient preference on specialist care

Gone are the days when dentistry meant extracting teeth and replacing them with dentures. Now it has grown into an integral part of modern health care with several specialties that offer various choices for the patient to retain their own teeth and improve the longevity and beauty of natural teeth. Patients have developed a liking for being treated by a specialist. They believe that the outcomes are better with specialists care and according to them it is their right to be referred to and being attended by one when a health situation demands.

Patients now prefer specialists to undertake specialty procedures, unlike in the past, claimed a senior general practitioner, with own dental clinic for more than two decades. She adds:

"Previously I used to manage all cases single handedly, including cyst enucleations and jaw fractures. Those days dental specialists were very few and hard to find. We were trained for that in medical colleges where post graduate students were only very few during that time. As house surgeons, we got a lot of experience those days in managing such cases. Patients also used to understand even if some minor complication happened. Now we have free availability of specialists and patients also come asking for specialists. Hence I no longer attempt any invasive procedures now, even though I am capable of doing, due to the fear of litigation for not referring such cases to specialist."

The practitioners following the trend, even in remote rural areas offer specialist consultations. General dentist have become facilitators of practice in multispecialty corporate clinics. The deployments of specialist have a big impact on the escalating treatment cost which in turn has influenced the doctor patient relationship.

According to a general dentist who works in a multispecialty corporate clinic, the job responsibility of a general dentist has shrunk to mere patient counselling and documentation. Most of the clinical work that requires the knowledge and skill of a general practitioner are now being carried out by concerned specialists. This has increased the treatment cost alarmingly.

c. Increasing number of dentists and unhealthy competition

There is an exponential increase of dental clinics and dentists passing out every year. Today there are 315 dental colleges in the country offering 26,969 BDS seats every year, most of the graduates and specialists are starting their own practice as public and private sector jobs are far and few. As the number of clinics mushroom, the patients get divided and many establishments are finding it difficult to sustain. This has led to dentists resorting to various means to woo patients which have led to an unhealthy competition at least in some regions. It was observed that this situation has severely affected the patients' trust. A senior general dentist, running her own practice in a rural area adds "*The bad competition for survival has led to unfair practices. Resultant bad experiences might have contributed to patients mistrust to the fraternity in general".* According to a senior lady specialist if asked about patient's opinion regarding suggested treatments, some time ago they would reply *"you are the doctor, you decide".* Now at least some patients feel that they know better than the doctors. They seek more time to decide regarding the treatment choices. This change in behaviour is more prevalent among the younger generation as observed from the participant responses.

According to another respondent *"the trust factor has come down, unethical practices from professionals have contributed to it in a big way".* She adds further that:

"Young patients are more sceptical and doubting. The older generation still trust you especially if they are your old clients. But once they become senior citizens and dependant they will be brought to the clinic by their grand children who are young adults. It is very difficult to convince them [grand children] regarding treatment decisions as they always put you under the scanner and compare with the social media knowledge with which they are obsessed with".

Another observation that many respondents shared is regarding doctor shopping and bargaining. Those who can afford bargain more when compared to financially weaker ones. Many doctors as well as clinics now offer packages and discounts to attract patients, which is again the bye product of increasing consumerism in healthcare. Having experienced this, patients try bargaining with other doctors also who run an otherwise old fashioned clinical service.

d. CPA and defensive practice

Ever since the enactment of Consumer Protection Act (CPA) and the inclusion of health care under its ambit, the doctor patient relationship has become formal. The clinicians are rigorously cautious and defensive in their practice. Although most participants were aware about the CPA, many had no clue regarding its implications and the extended protection it awards to patients as consumer. A minority of the participants who are actively involved with the indemnity scheme of Indian Dental Association (IDA) or are faculty in a dental/medical college; had fair understanding of CPA and its implications. But many clinicians were not well informed about CPA, which is noteworthy.

When asked about CPA, a junior resident in a dental college said

"I think I heard it [CPA] somewhere. But don't know much about it and not aware about how exactly it affects me. I am sure I have to be careful about it. I wish I had known more and somebody told us about it. I am sure many of my contemporaries are on the same page as me".

Clinicians who are familiar with CPA have suitably adapted their practice accordingly. They have stepped up the information sharing process with their patients. They take into account patient's satisfaction or at least make sure that patient's don't complain. A senior dental college faculty observes:

"I personally have resorted to something like a defensive practice. I always consider my safety and protection from any legality before I embark on some [clinical] procedure. I can afford to do so, because practice is part time for me"

Theme 2. Current Informed Consent Process: Ground Reality

a. Practitioner's understanding, apprehensions and expectations

All the participants who took part in the in depth interview demonstrated a reasonable awareness of the consent process. The level of understanding showed wide variation among participant categories. General dentist who were involved in primary care had only very basic information regarding consent process. Surgical specialists had reasonably good knowledge and dental/medical college faculty who were also involved in clinical research had a very good understanding. Cutting across participant categories and knowledge levels, everybody agreed that although its significance is increasing in the present times, it is not done as a mandatory thing for all routine procedures.

According to a respondent who is also a member of the Institutional ethics committee.

"In spite of being aware about it, the practice of taking informed consent may be less than 1% in routine dental practice. Not happening even in dental colleges, in the right way. What we have generally everywhere is a standard form on which signature is taken during registration which reads .I submit to all the dental procedures that is being carried out on me by the doctor, I have been informed about the same and I agree to it. But such a form will not stand in the court of law.

Another highly experienced University professor adds

"Those who claim that they take a signed consent are actually taking patients' signatures below these two non specific lines written on the back of the registration form. These universal forms won't work. Ideally it has to be specific for the condition to which it is sought. It has to be tailor made for each patient".

Some apprehended that introduction of consent forms for all cases would result in a change in practice culture which may be detrimental. An established practitioner who is running her practice for more than 20 years was of the opinion that

"It is difficult to introduce a universal written consent process all of a sudden to your old clients who trust you to the core. One fine morning when they come for a routine consultation if you ask them to sign consent first before the procedure they may feel bad or start doubting you. This may actually result in losing the trust and may strain the relationship."

The practicality of an ideal consent process for each and every routine dental procedures that are rarely highly invasive or life threatening has been questioned. Many had no idea about the various forms of consent like implied and express. Many believed that verbal consent is equivalent to no consent. According to a surgical specialist, "*whenever an informed consent is needed it has to be always written and verbal consent is a void*. He adds *"There is nothing like verbal consent, always needs written [consent]".* But the ethics committee member opines:

"Verbal consent is enough for most procedures that are simple and short. Only for invasive procedures, one [dentist] needs to obtain a signed written consent. In that case it has to be a prior informed consent obtained after providing ample time for the patient to think over and decide."

Opinion was divided with respect to getting the consent in the patient's own handwriting, A young lady practitioner vouched for getting it in patients own hand writing always. According to her *"it is invalid otherwise".*

But a more senior general practitioner was of the opinion that:

"Asking to write [consent] in his/her own handwriting is highly stressful for the patient as it mentions several complications of the procedure. It won't be a good idea to do this especially just before the procedure. Instead it is always better to use a printed form after a mutual process of dialogue and discussion."

Although majority of the practitioners are well aware of the consent process and the consequences of not abiding by it, they have other reasons for not putting it into their routine practice. It was noteworthy that 4 among the 14 respondents used to describe the consent process as a *double edged sword* totally unknowingly about others using the same phrase.

Budding professionals and junior specialists face a difficult initial period before they get established. The beginning phase is challenging for them and they see a written consent that lists all the complications as a threat. A young aspiring female practitioner who is just into building her own clientele says:

"I have just begun my profession. It is highly competitive and difficult to thrive in the time being. People like me fear that if a long list of complications [of the planned procedure] is disclosed to a patient, he/she may be turned off. It's scary. We beginners can't afford to lose our occasional patients. Hence written signed consent is very rare in our practice. Even if we take it we carefully avoid fearful words and situations in it."It would be just like inviting trouble". But so far so good, for God's grace. I keep it a point to explain all the good things about it [procedure] and educate those regarding instructions."

A rural general dentist adds "Currently I use a standard form to which I may add specifics depending upon the procedure. 25% patients still ask are they required to sign on this [consent]. But I don't insist, fearing not to lose the patient". Another practitioner was 'selective' in employing signed consent according to the situation. He adds:

"In my experience, certain patients are hesitant to put sign. Many withdraw at this stage [of consent] stating that they want to discuss with family, will think it over and revert, which happens rarely. Certain others get offended by asking to sign [consent]. They [patients] think that we [doctors] are trying to wash our hands [play safe]. So I don't employ it [consent] routinely. But I make it a point to obtain it [consent] from those who appear too sceptical and ask a lot of questions."

But most seniors who have several decades of busy practice are implementing the consent process for most of the procedures, without worrying much about losing patients just because of consent since they already are enjoying good professional reputation and goodwill.

The senior members were of the view that the gaining importance of consent is linked to the patients changed behaviour. The senior most participant says:

"Those days when I started practice around 30 yrs ago, nothing [consent] was taken. No information [about the procedure] was given. Nothing [was] taken in writing even for cases under GA [General Anaesthesia]. We have done elective cases [on patients] even without bystanders. But now we generally take a signed consent on a standard form. I personally try to avoid patients who are not willing to abide by signing the consent form, they are often the trouble makers."

A senior consultant periodontist emphasises that, "*Take it [consent] and you have peace of mind'.* Another respondent attached to a self financing dental college is of the opinion that obtaining a signed informed consent adds a lot of credibility to the professional. He continues *"It also makes one [dentist] more immune to litigation*". But another respondent (Government civil surgeon) who has given expert opinion to court for several dental litigations opines that "*taking consent is not a license to do a malpractice"*. Most respondents were of the view that communication with the patients is the key.

They also emphasized that documentation of the communication is also very important. A signed informed consent cannot substitute the detailed communication of the diagnosis and treatment plan and the documentation of the same. According to a participant who does a lot of cosmetic procedures:

"I spend a lot of time discussing things [related to the procedure] with the patient. I encourage them to ask all their doubts and I even give them a copy of the treatment notes to get a second opinion. Many patients appreciate this. In my opinion adhering to this [consent] will improve the patient's compliance; they adhere to instructions and never miss follow ups."

None of the participants have the practice of giving a copy of the consent form to the patient, instead they document it as part of their medical records.

b. Knowledge about procedures requiring consent

According to an oral and maxillofacial surgeon '*All procedures done under GA and all interventions with an irreversible nature should require a signed informed consent'*. A dental college faculty member is of the opinion that '*Except for simple procedures like scaling or filling which are non invasive or less invasive, all other procedures require signed consent.*

An implantologist adds:

"I will take a written consent for anything done under LA. For implants I also include post operative instructions, cost and follow up schedule. Because implant patients, I fear, have to be viewed more cautiously since the treatment cost is high. Anything untoward happens, there is more chance of them suing."

The cosmetic dentist suggests:

"Signed consent is mandatory for all cosmetic procedures, as there could be a mismatch between patients' expectations and the real [treatment] outcome. Apart from this for all surgeries major or minor, I do obtain consent. Also for all procedures that cost more than Rs.10, 000."

c. Awareness regarding legal requirements of informed consent

Critical assessment of the views expressed by the respondents suggests fairly good awareness among dental practitioners regarding the requirements of the consent process. But in terms of the awareness among practitioners regarding the legal validity of the consent they take, there are still a lot of grey areas.

Many had strange views regarding the requirements of consent. According to a junior dentist:

"It [consent] should include the patient's details, chief complaint and proposed treatment in detail including expected time taken for the procedure, Complications, expected outcome, but not a guaranteed outcome has to be mentioned".

The dentist who runs a chain of clinics suggests:

"There has to be a mention of the importance of follow up in the written consent. Also what the patient should do as post treatment care, without which the desired result could not be achieved."

Some respondents were very articulate about the quality of communication and the use of language during the consent process. According to another respondent who maintains an urban practice:

"The words and phrases used [in the consent] are critical. It should not scare the patient. Sometimes I feel that verbal consent is better as certain things can be better explained in a bilateral chat. Here the communication skills of the clinician come into play. If he is skilful enough he can convey all the facts and even worse complications without losing the patient".

Those clinicians who regularly perform advanced and invasive procedures under GA or LA feel that a prior consent is always beneficial. Practicality of prior consent is debatable. In this busy world, when someone finds time out of their overburdened daily schedule to fix an appointment with the doctor, they expect to get things done as early and fast as required. Even if the procedure in question is not an emergency, most patients would want to get the treatment done then and there if possible. Some even demands the same, if the dentist doesn't oblige they may find some other dentist who is willing to provide treatment the way they want. But if faced with any adversity following the treatment, the patients tend to forget that the treatment was done on demand and they may even claim that he/she was not properly informed about the pros and cons.

According to the senior most clinician:

*"*There is nothing like spending quality time with the patient while explaining the procedure'. Someone [doctors] who takes care to discuss about the treatment and procedure at length and is not annoyed by patients asking a lot of doubts generally gets good professional fame and goodwill in the long term." If you unduly oblige to the patient's needs sacrificing your responsibilities, you invite trouble."

The clinicians are confused as to the extent they explain the potential risks associated with the procedure. Most participants had the opinion that patients are worried about the complications and side effects and they rely on internet to get information regarding the same.

According to a young specialist

"I don't exactly know whether to disclose only the most common complications associated with the procedure or list all the complications, even the remotest ones. If I do the latter, I may lose more than half of my current patients. I cannot afford to do it."

That reveals although they would take a prior consent, it may not include those rare complications listed which the dentist fear would turn off the patient. Hence the consent in that particular situation may be inappropriate in terms of its legal validity.

The opinion was divided with respect to treatment cost in consent. A few respondents felt inclusion of treatment estimate would avoid plausible future disputes regarding payment. According to a senior specialist, *"It is thoroughly unprofessional to include costs [of treatment] in the consent. It may be given separately as treatment estimate".* Few of them actually include treatment cost in a range and get it signed and approved by the patient. A rural practitioner points out *'certain patients, these days, bargain in a dental clinic. It is better to include cost [of treatment] to avoid conflict after wards'.* Some senior clinicians were not in favour of including treatment cost in the consent form. A senior lady dentist suggests providing a treatment estimate in writing separately; as it would give a fairly good idea of the finances the patient has to arrange to get the treatment done.

Regarding getting consent for a child patient (minor), practitioners had mixed opinion with respect to the child's age to obtain a valid consent. Some felt that after 12 years, they can get it directly from a child. For some others it was 14 years. But nobody mentioned it as 18 years according to Indian legal system. The respondents were not much concerned about the legal validity of the consent process that they were following. What was more important to many was avoiding immediate complications and having a satisfied patient. The senior practitioners agreed that if the dentist behaves well, chances for litigation can be avoided to a great extent. Most respondents were of the opinion that establishing trust is the most important step and that takes some time. The morality and ethics of a clinician are being judged continuously by his /her patients. The patients trust can only be established if the treatment decisions taken by the dentist always consider the patients best interest.

Theme 3. Experience with dental litigation

None of the respondents had experienced any dental litigation suits against them. One of them, the senior most oral and maxillofacial surgeon who retired from the Government has been called to provide expert opinion on a few situations involving other dentists.

He shares his experience:
"I have given expert opinion on three situations. Out of which once the dentist had to pay compensation. The dentist didn't refer [the case] to a specialist when it was needed and continued to manage the case inappropriately and the patient had to suffer out of this act. In another situation it was due to improper communication on the part of the dentist that resulted in filing complaints, of not informing [treatment] charges in advance. The other one was a false claim. Both the complaints got dismissed."
Another dental college faculty adds:
"No personal experience so far by the grace of God. But one of my friends had to deal with a case following a surgical extraction. The patient developed paraesthesia. The patient was not informed about this accepted complication. I heard from him [friend] that the judge fined him for not producing a prior consent, even though the undesired outcome is an accepted complication".
The young female dentist who has just begun her practice says
"It's a matter of concern. It's not the money that we want to give as compensation thanks to the professional indemnity scheme of IDA, but our goodwill is at stake if it [litigation] happens to you".
The ethics committee member opines:
"We [Indians] have not come to that stage where a patient will take you to court every now and then. We are not hearing such things. But in future, going by the way dentistry is heading, we should be prepared to face it [litigation]. We should give importance to the consent form."
The rural general dentist was aware of a case of alleged loss of vision following dental extraction which was a falsified complaint. '*Even though it was not a case of malpractice, the dentist out of fear settled it out of court."*
The fear of defamation or loss of professional goodwill is the most worrying thing for a dental practitioner if involved in a dental malpractice suit.
Many believe that the patient's decision to complain against one dentist is often triggered by the opinion or attitude of another dentist. Many dentists forget the ethical obligation of not talking bad about the previous dentist or treatment. The participants in general were concerned about falsified complaints being raised. Professional regulatory bodies and other professional societies should educate and empower the fellow colleagues regarding this. They must also instil confidence in such situations so that the situation of litigation, genuine or otherwise, can be faced with confidence.
According to the urban dentist:
As there are more dentists, now the patients are at an advantage of choosing the one according to their wish. In order to impress them and to woo them, dentists resort to many gimmicks. This wins some times, but fails at other times. This makes the dentist vulnerable and invites litigations"
Disputes in doctor patient relationships are not uncommon. Many a times the reason for dispute is related to some complication following surgical extractions like restricted mouth opening and altered sensation in tongue or lower lips. Both these conditions are accepted complications of surgical removal of wisdom teeth in lower jaw which needs to be informed and explained in detail before actually performing the procedure at the time of consent. Another reason for dispute is dissatisfaction with a newly fabricated prosthesis. There is always a mismatch of expectations associated with any cosmetic intervention. To avoid this, the clinician and the patient have to be on the same page in terms of treatment outcome and expectations. This can be achieved only with an open conversation between the parties which leads to the consent process. A cosmetic dentist shares his personal experience of dispute with patients
"Unrealistic expectations with cosmetic treatments were the cause [of dispute] on all the occasions. None of them went to court as the issue was mitigated by refund of the professional charges. I learnt from that and now I make it a point to take a signed consent, provide an estimate in advance and also take clinical photographs at each step and document those".
In western countries the dental litigation is soaring in comparison to India. But it is expected to rise in India as well. Therefore sensitizing the professionals regrading legal aspects is very imminent. The professional regulatory body has recognized this; and attempts have been made by means of credit hours, the pandemic situation has stalled the efforts for the time being.

DISCUSSION

Many health care establishments in both private and public sector have been trying to engage with the patients through social media to impart relevant information, awareness and also to market their services[4]. There are other independent groups, health activists and non-governmental organisations that offer health care information for the benefit of the society. A systematic review on the effect of social media use in health care reports that although it leads to equal communication between doctors and patients it also leads to suboptimal interactions between them and increased doctor switching[5]. A plethora of factors have influenced the doctor patient relationship including commercialization of health care, emergence of self financing medical/dental colleges, the shrinking stake of the public sector in health care and ever increasing competition among professionals [6,7,8].

Kerala has the best dentist population ratio in the country (1:2200 as opposed to 1:10,000) and it is well above the WHO recommendation (1:7500) according to an old statistic and in 2030 it is expected to be 1:733[9]. The problem of plenty would have contributed to unhealthy competition.

The CPA 2019 is progressive as it encourages alternate dispute resolution (ADR) for speedy settlement of disputes, at the same time it has widened the scope for seeking redress for unfair medical practices and negligence[10].

Little research has happened regarding the assessment of the knowledge, attitudes and practices of dental practitioners with respect to informed consent in India. One study conducted in Punjab reported that the knowledge about informed consent process is linked with the experience and qualification of the dentists[2].

Dentists with more experience and post-graduation were better informed and demonstrated a positive attitude compared to those with less clinical experience. But when it comes to putting this into practice, more than 50% of the dentists didn't care to obtain consent prior to any dental procedure. Faehat et al 2013 attributes this to more number of patients seen on a day by an average Indian dentist, hurry in practice or negligence[11].

The Medical Council of India (MCI) has laid down guidelines regarding when to obtain a written consent[12]. This includes 'operations' and do not include other treatments. It suggests implied consent for routine type of treatments. Dental Council of India (DCI) has not formulated any similar guideline.

Hence there is a lack of clarity among practitioners and professional regulatory agencies with regard to the type of procedures that warrant a written and signed consent.

The onus is on the professional bodies to come up with such guidelines to clear the path ahead for a legal and ethical dental practice[1].

Legal literature emphasis to mention about material risks associated with the treatment/procedure in the consent process. But respondents were ignorant about the term in its spirit. There exists, among the clinicians, lack of clarity with respect to prior information to be given of the risks associated with the procedure. It brings to light a scope for massive improvement of ethical and legal literacy among dental practitioners. The presently undertaken continuing professional education programmes intended to meet this end may not be adequate and appropriate.

An informed consent will be valid only if the treatment is provided by an appropriately skilled and qualified professional who works within the frame work of the procedure for which the consent is taken and in a justifiable manner[13].

CONCLUSIONS

Three themes were identified based on the analysis of information gathered from the in depth interviews. Regarding the change in paradigm of doctor patient relationship, the use of social media has transformed the professional interactions leading to equal communications and increased switching of doctors. The health information it provides is beneficial in some way but it may also result in over expectations.

Both patients and hospitals/clinics prefer the services of specialists, but with escalation of treatment cost Hospital managements hire services of specialists more often in an attempt to avoid litigation. The exponential increase in the number of dentists has paved way for unhealthy peer competition that has a negative impact on patient's trust. The enactment of CPA made the doctors more conscious and many resorted to defensive practice.

The respondents had a reasonable understanding of the consent process. But most of them are not employing it in routine practice, those who do, use a nonspecific standard form. Many are apprehensive about the universal application of written consent forms to all procedures in most patients. Beginners are anxious about losing patients because of this. In general all of them agreed that the consent process in its intended manner is a *double edged sword.* The opinion was divided with respect to handing over a copy of consent to the patient and also regarding inclusion of treatment cost in consent.

There was a general agreement that all procedures done under GA and all invasive procedures that result in irreversible changes warrant a written consent. Some feel that all cosmetic procedures and all procedures that are costly also require a prior signed consent. Earnest efforts from the professional regulatory bodies are needed to bring in a lot of clarity regarding the dental procedures requiring consent.

The respondents had a fairly good idea about the legal requirements of consent, but a comprehensive understanding was lacking. The participants were of the opinion that a good bilateral communication which is free and fair does help to winning patient's confidence and trust. There was a lack of clarity with respect to the age of a minor to give a valid consent. Professional bodies and Government should take initiative to sensitize and update the clinicians regarding the ethical and legal requirements for a safe practice.

India has not witnessed a surge in dental litigations so far, but data suggests that it is steadily on the rise. With soaring competition, increasing consumerism in health care and better informed patients regarding their health rights, it is only a matter of time that we witness more litigation.

REFERENCES

1) Nandimath OV. Consent and medical treatment: The legal paradigm in India. Indian j Urol. 2009 Jul;25(3):343.
2) Gupta VV, Bhat N, Asawa K, Tak M, Bapat S, Chaturvedi P. Knowledge and attitude toward informed consent among private dental practitioners in bathinda city, punjab, India. Osong Public Health Res Perspect . 2015 Apr 1;6(2):73-8.
3) Thavarajah R, Saranya V, Priya B. The Indian dental litigation landscape: An analysis of judgments on dental negligence claims in Indian consumer redressal forums. J Forensic Leg Med. 2019 Nov 1;68:101863.
4) Amrita DB. Health care social media: expectations of users in a developing country. Med 2.0. 2013 Jul;2(2).
5) Smailhodzic E, Hooijsma W, Boonstra A, Langley DJ. Social media use in healthcare: A systematic review of effects on patients and on their relationship with healthcare professionals. BMC Health Serv. Res.2016 Dec;16(1):1-4.
6) Dash L.Healthcare Shopping: The new age of consumerism .The Financial Express. 2020 Jul 06
7) Mahal A, Mohanan M. Growth of private medical education in India. Med. Educ. 2006 Oct;40(10):1009-11.
8) Neelakantan M. Is Competition Law the Analgesic for the Indian Healthcare Sector. Nat'l L. Sch. India Rev. 2015;27:157.
9) Thomas S. Plenty and scarcity. Br Dent J. 2013;214(1):4. DOI: 10.1038/sj.bdj.2013.4
10) Nomani MZ, Rahman F, Alhalboosi AK. Consumer Protection Act, 2019 and its implications for the medical profession and health care services in India. J. Indian Acad. Forensic Med.2019;41(4):282-5.
11) Farhat W, Qiam F, Shah SM, Khan M, Khan H. Informed consent in dentistry: Percieved importance and limitations in Khyber Pukhtunkhwa. Cell J. 2013 Jun;333:9155592.
12) Gupta BD. The Indian medical council (professional conduct, etiquette and ethics) regulations, 2002: critical review and suggestions. Indian J. Forensic Med. Toxicol. 2003;20(1):4-7.
13) Holden AC, Stewart C. A review of the law of consent in dentistry. Aust. Dent. J.2019 Sep;64(3):208-12.

Table 1. Interview participant demographics

Variable	Practice experience (< 5 years)	Practice experience (> 5 years)	Total
Number of participants	6 (42.86)	8 (57.14)	14
Age	31.16	53.62	42.39
Gender			
• **Female**	4	5	9 (64.29)
• **Male**	2	3	5 (35.71)
Job title			
• **General dental practitioner**	3	3	6 (42.86)
• **Specialist**	2	3	5 (35.71)
• **Faculty**	1	2	3 (21.43)
Mean Interview time (minutes)	31. 15	33.58	32.36

Table 2. Themes and subthemes

Themes	Subthemes
Doctor Patient relationship- the changing paradigm	Influence of social media Increasing patient preference on specialist care Increasing number of dentists /unhealthy competition CPA/defensive practice
Current Informed Consent process- Ground reality	Practitioners understanding/apprehension/expectations Knowledge about procedures requiring consent Awareness regarding legal requirements of informed consent
Experience with dental litigation	