INTERPRETIVE STATEMENT REGARDING INFORMED CONSENT

To protect the public interest, the North Carolina Board of Dental Examiners (Board) provides interpretation and guidance regarding acceptable standards of care on the issue of patients' informed consent. Patients have the right to receive adequate information regarding proposed treatments or procedures to enable them to make informed decisions about their care. The patient's informed consent to treatments and procedures must be documented in the treatment record consistent with 21 NCAC 16T.0101 and 21 NCAC 16T.0103. [Link to Rules]

A dentist may satisfy the requirements of 21 NCAC 16T.0101 and 21 NCAC 16T.0103 for routine, low-risk procedures by personally discussing the procedures with the patient, or other person authorized to give informed consent on behalf of the patient, at the initial visit and by obtaining the patient's general consent to such procedures, which personal discussion with the dentist and general consent must be documented in the patient record. The general consent may apply to all routine, low-risk procedures performed at future visits. Examples of such low-risk, routine procedures and services include those defined under the Diagnostic, Preventive, and Restorative sections of the ADA Dental Procedures Codes (CDT Codes).

However, for treatments and procedures that are aimed at addressing a diagnosed condition, and that carry an increased risk for unwanted outcomes, the dentist must obtain the patient's informed consent for the specific treatment or procedure prior to undertaking such treatment or procedure, which personal discussion with the dentist and specific consent must be documented in the treatment record. Examples of treatments, services, or procedures that would require the dentist to separately document the patient's informed consent include those defined in the Endodontics, Periodontics, Prosthodontics (Removable and Fixed), Maxillofacial Prosthetics, Implant Services, Oral and Maxillofacial Surgery, Orthodontics, and Anesthesia sections of the CDT Codes.

Dentists can satisfy the requirement to document obtaining informed consent from the patient utilizing different methods, such as including it in the patient's clinical treatment record or chart, documenting it in the patient's electronic dental records, or using a separate written informed consent form, possibly signed and dated by the patient. The Board, however, cautions dentists against the overuse of templates and forms and emphasizes that the treatment record should reflect the actual exchange of information between the dentist and patient regarding the conditions diagnosed, proposed course of treatment, expected result, risks involved in treatment, and alternative treatment options.

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