From Informed Consent to Shared Decision-Making – what does it mean for dentistry?

SADJ AUGUST 2025, Vol. 80 No.7 P393-P394
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INTRODUCTION

Clinical decision-making has evolved from paternalism, where doctors decided what was best for the patient, to informed consent which is still widely used today. The concept of informed consent is governed by certain prerequisites which ensure that the patient makes an autonomous decision regarding their treatment after being presented with the risks and benefits of the available options. In medical negligence claims, the doctor's actions are assessed based on clinical judgement and whether a reasonable doctor in the same circumstances would have acted in the same way resulting in the same outcome. The Montogomery v Lanarkshire case of March 2015 in the United Kingdom for medical negligence[1], saw the court shift the focus away from the clinical judgement of the doctor's alleged negligence, declaring instead that the patient should have been given all options available to her, even if the doctor considered them to be unsuitable for her condition. Medical insurance companies quickly realised how the informed consent model made them vulnerable to medical negligence claims and amended their clauses accordingly. Clinical decisions now require a more personalised approach known as Shared Decision-Making (SDM). This article explores the main ethical principles that underpin SDM, what this means for the practice of dentistry and its effect on the dentist-patient relationship. Future research in this field could assess the success rate of implementation of SDM in different population contexts and geographical settings.

Shared Decision-Making in dentistry

SDM is defined as an approach where clinicians and patients make decisions together using the best available evidence.[2] In a paternalistic approach to decision-making, the patient is presented with the option deemed most suitable by the dentist and treatment is initiated. On the other extreme, in a patient-centred approach, the patient drives his treatment plan and may have unrealistic expectations surrounding his treatment outcome. When the clinical end-result does not meet the patient's expectations, doubt is unfairly cast upon the clinician's competence and there is a breakdown of trust. One of the core duties of a doctor as set out in the Health Professions Council of South Africa (HPCSA) guidelines[3] is to always act in the best interests of the patient. As such, a dentist presents feasible treatment options to a patient after applying his clinical insight and professional opinion to all aspects of the case. However, SDM insists that the patient be made aware of all options, even the non-feasible ones.

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The concept and process of Shared Decision-Making in dentistry

A few different SDM models currently exist, varying only slightly in their methods or the number of steps in their implementation. However, the overall concept remains the same:

1. Evidence-based information is communicated from clinician to patient
2. Factors specific to the patient and their circumstances are highlighted
3. The patient is allowed to deliberate on the available options and return to the clinician with concerns, queries or other possible options for treatment.
4. A final treatment decision is taken only once both clinician and patient are in mutual agreement.

This model is easily and successfully applied to most medical disciplines but there are limitations to the SDM model specific to dentistry.

Patient-specific limitations:• Literacy level
- Unrealistic expectations
- Financial constraints
- Anxiety
- Perceptions of family and friends placed above their own preferences
- Unwilling to set aside time for multiple appointments

Dentist-specific limitations:
- Continuous culture of learning and application of knowledge
- Maintenance of a high level of competence in clinical skills
- Time constraints that limit lengthy discussions regarding treatment plans
- Financial limitations – Longer appointment times lead to fewer patients seen

Dentistry-specific limitations:
- Cost and quality of different materials
- Rapidly changing technological advances in dentistry
- Necessary equipment can be expensive

Ethical Foundations and considerations of Shared Decision-Making in dentistry

Respect for autonomy – SDM allows more respect for patients' autonomy because they feel more involved in their treatment decisions. Patients are more likely to be satisfied with the end result if their preferences are taken into consideration. As

with informed consent, there can be challenges in assessing a patient's capacity and understanding as dental jargon must be simplified for any individual, educated or not, who is unfamiliar with these terms.

Beneficence and Non-Maleficence – The dentist is obligated to act in the best interests of the patient. This can become difficult when the dentist must balance his professional recommendations while taking patient preferences into consideration. If not done in a diplomatic manner, it can seem that the dentist is trying to force the patient to agree to a specific treatment. These discussions are easier in emergency situations, however in a purely elective procedure it is difficult to balance good clinical judgement with patient autonomy.

CONCLUSION

It is the professional obligation of the dentist to provide patients with all the necessary information regarding their treatment options. However, this ideal is affected by the fact that patients vary greatly in their level of capacity and competence, socio-economic status and personal preferences. There is a risk of patients feeling overwhelmed by the amount of information being given to them especially if there are barriers to communication like language or cognitive impairment. Time and cost restraints are a prominent feature of a dental practice and these are barriers to the successful implementation of SDM in dentistry.

It remains the ethical duty of dental professionals to facilitate informed choices by maintaining a culture of continuous learning in the clinical sphere as well in communication and ethical reasoning. Decision aids and visual tools are an option to clarify concepts to patients but these must also be used in an ethical manner. Most importantly, the dentist must be meticulous about comprehensive documentation in any patient discussion to avoid any legal implications which may arise from the event.

As we move away from the construct of informed consent and towards Shared Decision-Making, it is evident that there is a need for ethical guidelines specific to dentistry that will protect both the dentist and the patient.

REFERENCES

1. Chan S W, Tulloch E, Cooper E S, Smith A, Wojcik W, Norman J E et al. Montgomery and informed consent: where are we now? BMJ 2017; 357 :j2224 doi:10.1136/bmj.j2224
2. Elwyn G, Laitner S, Coulter A, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. BMJ. 2010 Oct 14;341:c5146. doi: 10.1136/bmj.c5146. PMID: 20947577.
3. Health Professions Council of South Africa. General Ethical Guidelines for the Health Professions. Booklet 1. Guidelines for good practice in the health care professions. Pretoria, May 2008

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