Informed consent is the process by which a fully informed patient can participate in the choices regarding their health. Of course you cannot simply launch into treatment, as with all forms of medicine and dentistry, patient consent is needed. This has to be based on knowing and understanding the factors involved with treatment and their alternatives. In endodontics, the decision needs to be made as to whether to treat the tooth or to extract it. The patient needs to make an informed choice and has to understand the prognosis and any risks involved. The more thorough the discussion at this stage, the less likely there are to be problems later.

Root canals are not simple straight tubes, but complicated three-dimensional structures full of nooks and crannies harbouring bacteria and therefore it is impossible (as with any other complex biological system) to offer absolute guarantees, and the patient needs to understand this.

Highlight the options
First, give them a clear and concise prognosis of each treatment option. Vital inflamed teeth with no infection have an excellent prognosis with a quoted success rate of approximately 95 per cent. If the tooth is infected with a lesion, the success rate may drop down to 80 per cent. The patient also has to be made aware that ideally the tooth may need a crown in the future to prevent fracture, and that treatment cost may not just be endodontic.

The initial decision has to be made as to whether the tooth is restorable. Most teeth can be root-filled, but if there is not enough coronal tissue it may not be worth it. If the tooth has an uncertain prognosis, then there should be a discussion regarding the merits of treatment versus extraction and replacement with a bridge/implant.

The patient’s personal feelings, experience and aspirations feed into the process of informed consent as well as any cosmetic implications.

Easy does it
The following scripted conversation only takes about five minutes, but gives the patient real information that leads to valid consent and could help to prevent problems arising from any misunderstanding of the treatment plan:

‘Mrs Jones, your lower tooth has become infected and needs root canal treatment. The success rate, according to figures is about 80 per cent, unfortunately not a 100 per cent guarantee. However, to really protect the tooth, it should ideally have a crown put on it as well. Looking at the tooth, it may be difficult to get a good crown on it and the alternatives may be to have the tooth extracted.

‘If you lose the tooth, you will have a gap. Nobody has died of a gap so far but it may have an knock-on effect on the other teeth and they may change position.

Endodontic consent — an efficient script
Dr Michael Sultan emphasises the importance of explaining fully the choices a patient has when it comes to what’s involved in their endo treatment so they can make the right decision.
‘You may want to also think about a bridge. This will involve reducing the adjacent teeth and preparing them for crowns. All the teeth are linked so it may be difficult to clean, but it is a relatively cheap and easy procedure. The half-life of a bridge is approximately 10 years so it will not last a lifetime.

‘The best option is to have an implant. This is a screw placed into the bone, it involves surgery but we do not have to touch the other teeth so you can clean around it easily. The downside is that it is more expensive and you need good bone.

‘Mrs Jones what would you like us to do?’

‘It’s really as simple as that and your patient will certainly thank you for it in the long run.’

**About the author**

Dr Michael Sultan
BDS MSc DFO is a specialist in endodontics and the clinical director of Endocarp. Michael qualified at Bristol University in 1986 and worked as a general dental practitioner for five years before commencing specialist studies at Guy’s Hospital in London. He completed his MSc and in endodontics in 1993 and worked as an in-house endodontist in various practices before setting up on his own at London’s Harley Street in 2000. He was admitted on to the specialist register in endodontics in 1999 and has lectured extensively to postgraduate dental groups as well as lecturing on endodontic courses at the Eastman Dental Institute at University of London. He has been involved with numerous dental groups and has been chairman of the Alpha Omega dental fraternity. In 2008, he became clinical director of Endocarp, a group of specialist practices. Dr Michael Sultan can be contacted for advice regarding patients or any issues raised in his articles, on michael@endocap.co.uk.