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Failure to obtain informed consent should also be considered an adverse event

**KEYWORDS**

Informed consent;
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Culture in patient safety is a challenge in healthcare, and “adverse events” (AEs) can cause serious injuries that, in many cases, can be preventable. Although dental care can also produce AEs, we agree with Cheng et al. (2019) that there is a lack of information regarding risks of causing harm to patients and “gaps between attitudes and actual practice behaviors toward patient safety”.¹ A deeper approach has been suggested to identify potential AEs existing within dental care.² Specifically, obtaining informed consent (IC) as an important part of the shared decision-making process,³ involves several variables, many of which are also likely to originate AEs if the IC fails to validate itself as a genuine ethical and legal process. We presented a case in that the failure to properly obtain an IC for a surgical procedure in the dental office resulted in an “excess of treatment” and in the production of a serious AE.

A 43-year-old woman came to our centre, asking for an analysis of serious injuries caused by three dental procedures realized on one surgical act a year before: i) the extraction of the left mandibular first molar, ii) positioning of implant in the extraction socket of the left mandibular first molar, and iii) the extraction of the third molar of the same side. These procedures caused the unfavorable fracture of the mandible and irreparable damage to the inferior alveolar nerve. According to the patient, immediately after the extraction of the first molar and the placement of the implant, while still under the effects of the anesthetics, the professional suggested to also extract

the third molar (procedure originally programmed for another clinical appointment due to its complexity), which she agreed to, resulting in the previously described consequences.

After analyzing every aspect of the described case, we reported that there was causality between the procedure and the injuries due to lack of adherence to the Lex artis. Leaving aside the technical elements, and far beyond the poor quality of the information provided to the patient, the obligation to request consent in a timely manner for the extraction of the third molar was vulnerated due to the timing of the procedure and the affected damage perception of the patient, clearly biased by the anesthetic blocking. The decision of the professional to move forward into a risky surgical procedure (Fig. 1), not programmed for that clinical session and not even urgent, could be qualified as reckless, unnecessary and evidently not beneficial to the patient. The necessary time for the patient to reflect about the procedure was not considered and the immediacy of the risky surgical procedure based on a biased consent, weaken the defense of the professional and where added to the necessary elements to give sufficiency to an infraction of the Lex Artis. Beyond the different international laws, obtaining the IC should receive greater attention due to its impact on patient safety. Improperly obtaining IC can cause AEs and odontologists may underestimate the ethico-legal elements of a properly obtained document representing a gap between attitude and actual dental practice.

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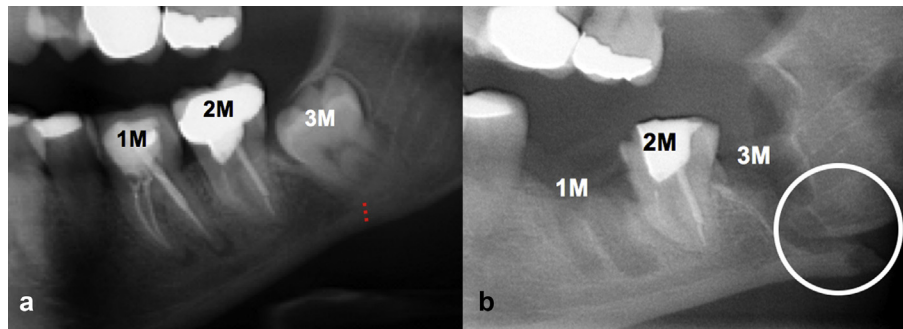


Figure 1 a) Panoramic radiography showing the preoperative status of the patient. Note the profoundly impacted lower third molar (3M), which added to the bone thinning (red line) and the age of the patient, determine a high probability of mandible fracture. b) Panoramic radiography showing the postoperative status of the patient, 6 days after the event. Note the post-extraction socket of the first molar (1M), the implant' space imprudently removed by the surgeon, and of the post-extraction socket of the 3M showing a complicated fracture of the mandibular angle (Circle). See the damage produced by excessive intra-operative maneuvers in the second molar (2M).

Declaration of Competing Interest

The authors have no conflicts of interests.

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