Revista Odontológica Mexicana
Órgano Oficial de la Facultad de Odontología UNAM

Letter to the editor

Informed Consent as an Expression of Autonomy in the Dental Patient

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Received: October 2022
Accepted: May 2023

Cite as:
Santos Pérez Y. El consentimiento informado como expresión de autonomía en el paciente odontológico [Informed Consent as an Expression of Autonomy in the Dental Patient]. *Rev Odont Mex*. 2023; *27*(2): 1-3. DOI: 10.22201/fo.1870199xp.2023.27.2.84899

Mr. Editor:

For *Beauchamp and Childress*[1], the autonomous individual is one who "*acts freely by a self-chosen plan*". For its part, the American College of Physicians defined Informed Consent (IC) as "*the explanation to an attentive and mentally competent patient of the nature of his disease, as well as the balance of the effects of the disease and the risk of the recommended diagnostic and therapeutic procedures, and then requesting his approval to undergo such procedures*". The same instance adds: "*The presentation of information should be understandable and unbiased (...), the patient's collaboration should be obtained without coercion and (...) the physician should not take advantage of his potential psychological dominance over the* patient»[2,3].

Sometimes the defense of autonomy is confused or equated with IC, especially in clinical ethics. It is a reprehensible practice of some health professionals who use IC documents not to certify that the patient has received the relevant information for his case, that he has understood it correctly, and that he assumes, without any kind of coercion, the reasonable

consequences of the treatment proposed by the physician, but as a way of protecting themselves legally against possible complaints by the patient. This perversion of the purpose of the IC causes the usual scenes of making patients sign papers with excessive and even grotesque small print as if it were a contract trap, or of making them sign without further explanation of what is being signed and why, and even of sometimes using the preoperative period to comply with the signing procedure.

Sometimes, the best protection of patients' will is not achieved by simply accepting their declared preferences. But not because these preferences should not be considered, but because they must be protected from the pressure they receive from third parties to accept or refuse certain treatments. Covert pressures or coercion that easily go unnoticed by a defender of autonomy who renounced reasonable paternalism in the name of the sacred right to autonomy. The declared preferences of the sick, especially of the most socially vulnerable (adolescents, the elderly, women trapped in a highly sexist environment, people with a lack of education, the poor, the marginalized, immigrants, etc.) do not always reflect their true preferences, those they would have if they were not in a situation of social defenselessness, which would be added to the natural or inherent vulnerability of the disease.

The ideal protection of autonomy is far from being the actual practice faced every day by patients and professionals. For this reason, the defense of autonomy must be accompanied by a reasonable paternalism aimed at promoting the real autonomy of the most vulnerable people. This type of paternalism not only does not contradict the principle of autonomy but is one of its conditions. What is difficult, however, is to know how to discern when paternalism serves autonomy and when it only serves the interests of those who exercise it. However, this is a bioethical problem that cannot be solved either by ignoring it or by reducing it to an unconditional defense of the declared preferences of the most socially vulnerable patients. The validity of the consent does not in itself justify the protection of the patient's autonomy. This is why the aim of an Ethics Committee is not only to validate the obtaining of the IC but above all to ensure that the design and conditions of the procedure are appropriate, and that the procedure is carried out as planned. It is not only a matter of informing the subject properly and verifying that the IC has been obtained correctly, but also of protecting the subject from possible unjustified harm.

In recent years, the changes that have taken place in the health area and, in particular, in dentistry, have led to the birth of a new paradigm in the dentist-patient relationship. The change from the paternalistic model to the new prevailing autonomic model requires the professional to inform the patients about everything concerning their oral health. For this reason, the IC model is implemented in dentistry, which allows the consolidation of the bioethical foundation in the dentist-patient relationship, since it is based on respect for the patient's will and autonomy to decide on his or her treatment[4,5].

Education in dentistry should be based on values and not theoretical-practical clinical training, where learning is focused on the number of requirements to be fulfilled, which leads to difficulties in the relationship between the student and the patient. It is necessary to emphasize the responsibility of higher education institutions to address in-depth aspects inherent to the bioethical and legal principles of IC within the undergraduate and graduate curricula, mainly to ensure a good dentist-patient relationship. Teaching about the use and importance of IC is part of the curriculum of most dental schools. However, the way it should be taught requires a practical approach and a relation to real situations, with which the student will be confronted throughout his or her professional life. This requires the application of methodologies that encourage critical reasoning and decision making, within a real socio-cultural framework.

In summary, the fundamental principle in the bioethical assessment of the patient is the IC of the subject in question as a magna representation of his or her autonomy. This consent guarantees their freedom, which cannot be compromised by any imposition or utilitarian interests. It primarily determines the success of the professional performance, where the harmony and balance of its dimensions are important so that the relationship achieved is maintained within the limits of human dignity.

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