# Awareness of Consumer Protection Act among Dental Health Professionals in Dental Schools of Ghaziabad, India

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**Abstract**

**Aim:** The study aimed to assess the awareness of the Consumer Protection Act among dental health professionals in dental schools of Ghaziabad, India.

**Materials and methods:** A cross-sectional questionnaire survey was carried out on dental health professionals in dental schools of Ghaziabad, India. A total of 348 dental health professionals (170 males and 178 females) were surveyed, out of which 116 were MDS faculty, 45 were BDS faculty and 187 were pursuing post graduation. The questionnaire comprised of 24 questions about the awareness of consumer protection act. Statistical analysis was done using Chi-square test, student's t test and ANOVA.

**Results:** A total of 84.8% (n=295) reported to be aware of consumer protection act. Amongst them, MDS faculty showed more awareness as compared to BDS faculty and those pursuing post-graduation.

**Conclusion:** Considering the present scenario, MDS faculty dental professionals have more awareness of consumer protection act compared to other dental professionals. So, we must upgrade our knowledge on consumer protection act at all levels of our profession and change our attitude by inculcating a practice to spread the message of consumer protection act for delivering quality dental care.

*Key Words: Awareness, BDS Faculty, Consumer Protection Act, Dental Schools, MDS Faculty, Post-graduate Students*

## Introduction

"I swear by Apollo Physician, by Asclepius, by Health, by Heal-all, and by all the gods and goddesses, making them witness, that I will carry out, according to my ability and judgement. I will use treatment to help the sick according to my ability and judgement, but I will never use it to injure or wrong them." (Hippocrates oath).

The dental profession is a vocation in which knowledge and skill is used for the service of others. Being a dental health care provider, it carries with it a responsibility to individual patients and society. The special status that society confers on the dental professionals requires them to behave in an ethical manner. This responsibility should be at the core of the dental professional's ethical behaviour [1].

The profession of dentistry has seen unprecedented change during the last century [2]. We have moved from a paternalistic view of medicine in which the dentist decided what was best for the patient [3]. Today, however, there is a new alliance between the dentist and patient, based on co-operation rather than confrontation, in which the dentist must 'understand the patient as a unique human being'. More and more patients are getting aware of their rights and are keen to make free choices and decisions on their treatment. So, there is a duty on the part of the dentist to perform such obligation with proper care [4].

Consent has formed an integral part of patient treatment and management. The concept of informed consent arises from the fundamental ethical principle of autonomy and rights of self determination. The core idea of autonomy is one's action and decisions are one's own [5].

Examination of a patient to diagnose, to treat or to operate without his/ her consent amounts to an assault in law, even if it is beneficial and done in good faith. The dentist may be charged for negligence, if he/she fails to give the required information to the patient before obtaining his/ her consent to a particular interventional procedure [6].

However, patients are sometimes dissatisfied with the treatment they receive from their dentists. In most cases, such dissatisfaction can be resolved between the patient and the dentist but sometimes the patient turns to a legally competent body which can judge whether the complaint is reasonable and if necessary, takes subsequent action against the dentist [7].

Throughout the world, patients have become more aware of their right-legal literacy supplemented by modern legislation has made the society increasingly compensation–oriented. India is no exception and, in recent years, there has been a steady rise in the number of all classes of claims in which damages are sought for personal injuries-whether they are sustained in road accident, at the work place, or in health services [8]. Consumer Protection Act of 1986 was enacted for better protection of the interests of consumer grievances. This is done through judicial mechanisms set up at district, state, and national levels where consumers can file their complaints, which are entertained by the judicial bodies referred to as consumer forums. These consumer forums have been empowered to award compensation to aggrieved consumers for the hardships that they have endured [9].

Complaints from patients about dental treatment are on the increase internationally, especially in the USA [10,11]. Rudov et al. found that dentists accounted for 6.9% of all malpractice claims closed in 1970 [12]. The incidence rate of

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dentists with at least one claim filed between 1988 and 1992 was 73 per 1,000 dentists. The number of dentists reporting at least one filed claim ranged from 11 per 1000 dentists in 1988 to 27 per 1000 dentists in 1992 [13]. In UK, the situation is not different. The number of dentists reporting complaints has shown a gradual rise from 3.5% in 1989 to 10.7% in 1992 [14].

Studies on awareness among dental health professionals about laws related to the Consumer Protection Act (CPA) have rarely been reported in literature, hence the present study was undertaken.

## Aim

The study aimed to assess the awareness of consumer protection act among dental health professionals in the dental schools of Ghaziabad, India.

## Material and Methods

A descriptive cross-sectional questionnaire survey was carried out on dental health professionals in dental schools of Ghaziabad, India from August to October 2011.

From a total of seven dental schools in Ghaziabad (U.P. state) India, only five dental schools were having post graduate dental courses and hence five dental schools were selected for the study. Pilot study was done in one dental school and the remaining four dental schools were included for the main survey. Ethical approval was obtained for the study from the Institutional Review Board of the college. A written informed consent was obtained from all the participants and prior permission was obtained from the concerned college authorities. The study population consisted of MDS faculty, BDS faculty and post-graduate students.

Prior to the data collection, the questionnaire was pre-tested among 60 dental professionals including BDS faculty, MDS faculty and post graduate students in one dental school, in order to ensure the level of validity and reliability. The sample size was determined based on the results of the pilot study using the formula - $4pq/l^2$ and the data of the pilot study was not included in the main survey. The final sample size was 322.

The total number of dental professionals in four dental schools was 375. All dental professionals from four dental schools were included for the survey. The total number of BDS faculty in four dental schools was 51 (10 in dental school 1, 13 in dental school 2, 12 in dental school 3 and 16 in dental school 4); MDS faculty was 129 (32 in dental school 1, 34 in dental school 2, 29 in dental school 3 and 34 in dental school 4) and post graduate students was 195 (44 in dental school 1, 48 in dental school 2, 50 in dental school 3 and 53 in dental school 4).

A self administered, structured, closed ended questionnaire written in English was designed. The questionnaire consisted of 24 questions based on awareness, objectives and applicability of CPA, location of consumer forums, conditions where patient can sue a doctor, time period for a patient to sue a doctor, maximum compensation that can be claimed, and questions relating to consent in daily practice were included.

The study participants were given a questionnaire on the day of visit by a single investigator. The participants were asked to respond to each item according to the response format provided in the questionnaire. The participants received a full explanation of how to fill in the questionnaire. It was later checked by the investigator in case any of the questions were left unanswered. The questionnaire was collected at the same time by the investigator.

The data was analyzed using SPSS version 18. Student's t test, ANOVA and Chi-square test was applied with p value $\leq$ 0.05 considered to be statistically significant.

## Results

A total of 375 dental health professionals were surveyed, of whom 365 agreed to participate. A further 17 were excluded due to incomplete filling of the questionnaire, for referring books, discussing or referring the internet. So, the final sample consisted of 348 dental health professionals.

The details of the participating dental professionals according to gender, level of education and years of experience in the field is shown in *Table 1*. 48.9% (n=170) and 51.1% (n=178) of the study subjects were males and females respectively. 12.9% (n=45), 33.3% (n=116) and 53.8% (n=187) of the study subjects were BDS faculty, MDS faculty and post graduate students respectively. Majority of the study subjects (56.3%) were having experience of less than 5 years. 25.9%, 11.2% and 6.6% of the study subjects were having 5-10 years, 11-15 years and more than 16 years of experience. Out of 348 participants, 84.8% (n=295) were aware of consumer protection act and 15.2% (n=53) were unaware of the act.

In the present study, females had a slight higher awareness of CPA compared to males in all professional groups which was not statistically significant (p=0.09). However, regarding level of education, MDS faculty had higher awareness of CPA compared to BDS faculty and post graduate students (p=0.001). According to years of experience in this field, dentists with 16 years of experience and above had higher mean scores of CPA compared to others (p=0.001) (*Table 2*).

Regarding the objectives of consumer protection act, 89.2% of the MDS faculty, 75% of BDS faculty and 72.6% of those pursuing post-graduation were aware of settlement of disputes within 90 days of complaint. About 92.2% of the MDS faculty, 86.1% of BDS faculty and 82.2% of post-graduate students were sure of the applicability of CPA to

***Table 1.*** *Distribution of study subjects according to gender, level of education and years of experience.*

| Characteristics | | Number | Percentage |
|---|---|---|---|
| **Gender** | **Male** | 170 | 48.9 |
| | **Female** | 178 | 51.1 |
| **Level of education** | **BDS faculty** | 45 | 12.9 |
| | **MDS faculty** | 116 | 33.3 |
| | **Postgraduate students** | 187 | 53.8 |
| **Years of experience** | **<5 years** | 196 | 56.3 |
| | **5-10 years** | 90 | 25.9 |
| | **11-15 years** | 39 | 11.2 |
| | **16 years and above** | 23 | 6.6 |

patients of nursing homes, private practitioners and hospitals having free as well as paying patients (*Table 3*).

55.6% of BDS faculty, 51.6% of postgraduate students and 37.3% of MDS faculty were unaware of the location of consumer dispute redressal forums. It was also surprising to note that majority of the participants were unaware of the location of the consumer forum in their own area (*Table 3*).

In response to a question, can a consumer lodge a complaint without the presence of a lawyer, MDS faculty (85.3%) was more aware as compared to other dental professionals that a complaint can be lodged against the concerned doctor even without the presence of lawyer. Approximately one fourth of the dental professionals did not know that a doctor can sue a patient with respect to payment or services while 78.4% of MDS faculty reported that a patient can sue a doctor for rejecting either an emergency case or medically compromised case (*Table 3*).

Majority of the post graduate students (84.1%) and MDS faculty (80.4%) agreed that the doctor is liable for those which are a consequence of a breach of his/her duty. Even for the negligence of junior staff the doctor is held liable; 30.6% of BDS faculty, 23.5% of MDS faculty and 20.4% of postgraduate students disagreed. When it was asked that the hospital and not the doctor is liable for the negligence of its employee in case of government or private hospital, 61.1% of BDS faculty, 57.4% of postgraduate students and 53.9% of MDS faculty agreed upon it. 91.7% of BDS faculty reported that it is the duty of the doctor to warn the patient of the risk that can occur even under emergency situation while 21.7% of postgraduate students disagreed (*Table 3*).

It was interesting to find that 54.8% of postgraduate students, 44.1% of MDS faculty and 33.3% of BDS faculty were unaware of the fact that the beneficiaries in case of mishap of a minor case are both child and parents/guardian. In case a patient is diagnosed with AIDS, majority of the participants were of the opinion that the treatment in that case cannot be refused while still 11.8% of MDS faculty, 10.8% of postgraduate students believed that the treatment can be refused. Regarding the refusal of treatment in case a patient is not well dressed (e.g. torn clothes, dirty clothes, revealing clothes) few participants (25% of BDS faculty, 4.9% of MDS faculty and 3.2% of postgraduate students) were of the opinion that the treatment can be refused for those patients (*Table 3*).

It was surprising to note that only 15.7% of MDS faculty, 8.3% of BDS faculty and 8.3% of postgraduate students were aware of the maximum compensation that can be claimed by the patient (p=0.002). Majority of the participants did not even know the maximum compensation of more than 171192 USD that can be claimed by the patient (*Figure 1*). The maximum time period within which a patient can sue the concerned doctor with evidence was reported correct only by 13.9% of BDS faculty, 21.6% of MDS faculty and 18.5% of

***Table 2:*** *Awareness of consumer protection act according to gender, level of education and years of experience.*

| Characteristics | | Number | Mean | SD | p value |
|---|---|---|---|---|---|
| **Gender** | **Male** | 170 | 13.71 | 7.29 | 0.09+** |
| | **Female** | 178 | 14.99 | 6.77 | |
| **Level of education** | **BDS faculty** | 45 | 13.49 | 6.77 | 0.001++* |
| | **MDS faculty** | 116 | 15.20 | 6.83 | |
| | **Postgraduate students** | 187 | 14.05 | 7.23 | |
| **Years of experience** | **< 5 years** | 196 | 14.67 | 6.59 | 0.001++* |
| | **5-10 years** | 90 | 14.52 | 7.23 | |
| | **11-15 years** | 39 | 12.05 | 8.71 | |
| | **16 years and above** | 23 | 15.00 | 6.74 | |

+ Student's t test, ++ ANOVA test
* Significant, ** Non-significant

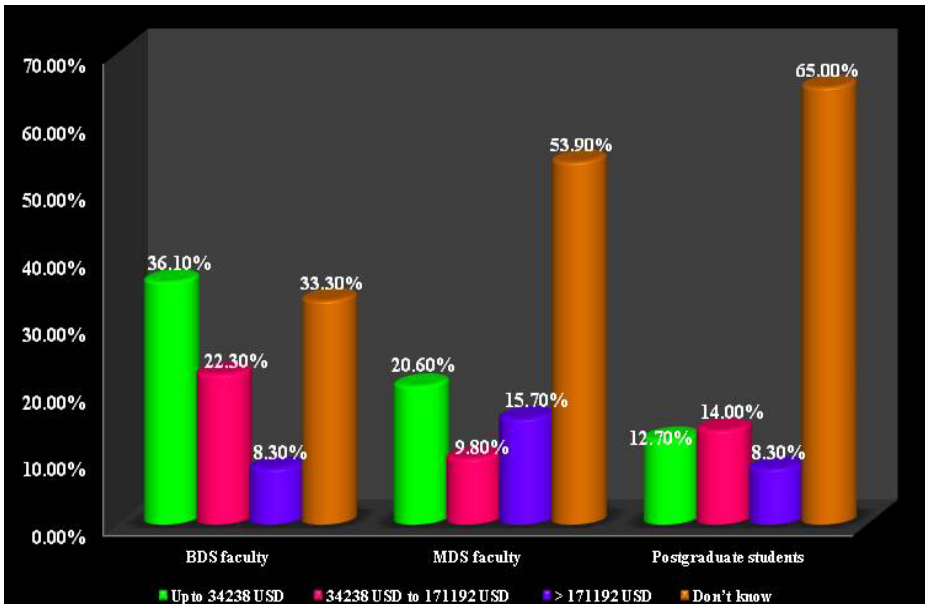


***Figure 1.*** *Maximum compensation that can be claimed by the patient.*

postgraduate students (p=0.818). Almost one fourth of the individuals did not even know the maximum time period to sue the concerned doctor is within two years (*Figure 2*).

Approximately 90% of the dental professionals reported that they take consent from the patients prior to the start of any procedure and the type of consent which can be relied is informed consent (*Figure 3*). The type of consent obtained from an illiterate patient is verbal consent and thumbprint as reported by 65.6% of MDS faculty. Majority of the subjects knew that for a patient under 15 years of age, consent for examination is taken from parent or guardian (*Table 4*).

About 84.4% of MDS faculty, 83.4% of BDS faculty and 77.7% of postgraduate students were unaware that the consent needs not to be taken for immigrants under the consumer protection act. When it was asked what should be done to informed consent after treatment, around 90% of the participants were aware that it should be preserved by the dentist. Only 58.3% of BDS faculty, 43.3% of postgraduate student and 38.3% of MDS faculty agreed that in case the patient asks to take a copy of the consent form, it should be provided willingly (*Table 4*).

## Discussion

The enactment of the Consumer Protection Act, 1986, is a milestone in the history of socio-economic legislation in India. The Act has considerably consolidated the process of consumer protection and has given rise to new consumer jurisprudence during the past few years. However, awareness among dental health professionals about such laws is observed to be varied. Thus, it becomes important for the dental professionals today to explain patients about their treatment needs, expenditure and risks involved and routinely obtain consent for all procedures.

The present study was conducted to assess the awareness of consumer protection act among dental health professionals in dental schools of Ghaziabad, India. We found that MDS faculty was more aware as compared to BDS faculty and post graduate students. This was in accordance to the study done in Udaipur city, India which showed that postgraduates were more aware as compared to undergraduates [9]. Another study done in India which showed that only 1 intern, 2 postgraduate students and 2 tutors were unaware of consumer protection

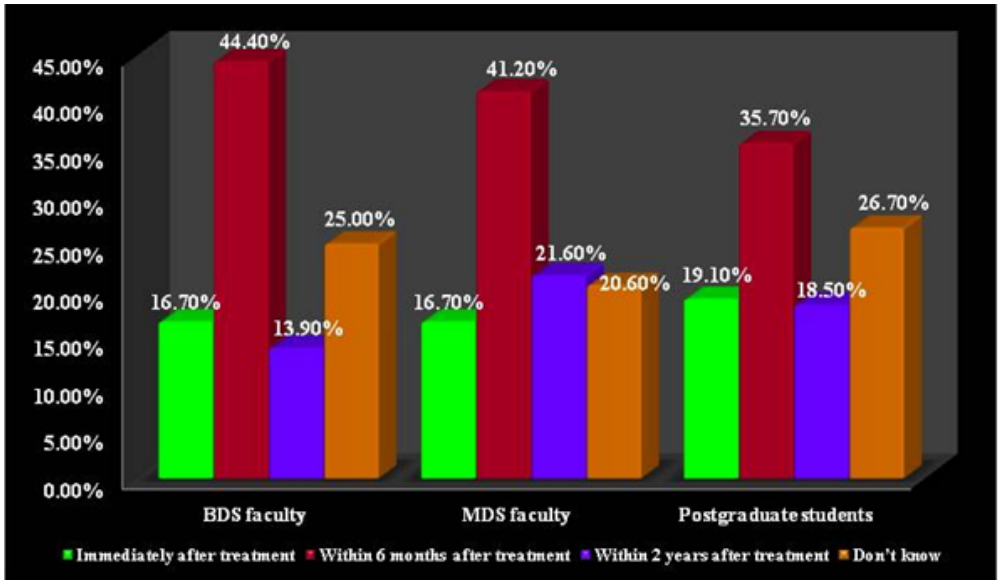


***Figure 2.*** *Maximum time period within which a patient can sue the concerned doctor with evidence.*

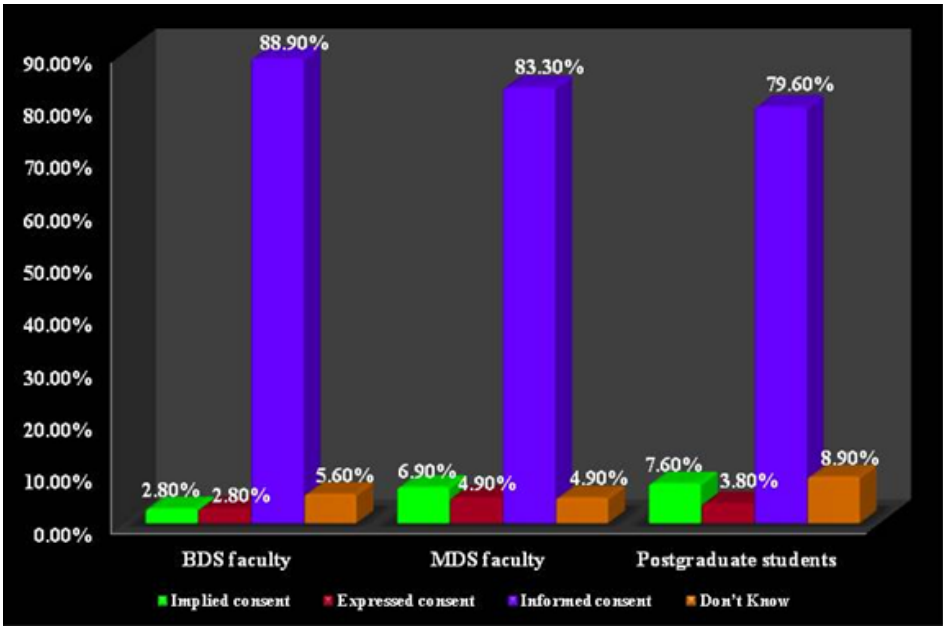


***Figure 3.*** *Type of consent to be relied.*

***Table 3.*** *Responses to various questions by the study participants.*

| Questions | Responses | BDS faculty | MDS faculty | Postgraduate students | p value |
|---|---|---|---|---|---|
| **Objectives of Consumer Protection Act** | Aware | 27 (75%) | 91 (89.2%) | 114 (72.6%) | 0.025* |
| | Unaware | 9 (25%) | 11 (10.8%) | 43 (27.4%) | |
| **Applicability of Consumer Protection Act** | Aware | 31 (86.1%) | 94 (92.2%) | 129 (82.2%) | 0.209** |
| | Unaware | 5 (13.9%) | 8 (7.8%) | 28 (17.8%) | |
| **Location of Consumer Dispute Redressal Forums** | Aware | 16 (44.4%) | 64 (62.7%) | 76 (48.4%) | 0.136** |
| | Unaware | 20 (55.6%) | 38 (37.3%) | 81(51.6%) | |
| **Location of Consumer Forums in your area** | Aware | 11 (30.6%) | 47 (46.1%) | 64 (40.8%) | 0.349** |
| | Unaware | 25 (69.4%) | 55 (53.9%) | 93 (59.2%) | |
| **Can a consumer lodge a complaint without the presence of a lawyer?** | Yes | 25 (69.5%) | 87 (85.3%) | 109 (69.5%) | 0.077** |
| | No | 5 (13.8%) | 11 (10.8%) | 25 (15.9%) | |
| | Don't Know | 6 (16.6%) | 4 (3.9%) | 23 (14.6%) | |
| **Can a doctor sue a patient with respect to payment or services?** | Yes | 13 (36.1%) | 59 (57.8%) | 71 (45.2%) | 0.105** |
| | No | 14 (38.9%) | 22 (21.6%) | 53 (33.8%) | |
| | Don't Know | 9 (25.0%) | 21 (20.6%) | 33 (21.0%) | |
| **Can a patient sue a doctor for rejecting an emergency case/medically compromised case?** | Yes | 23 (63.9%) | 80 (78.4%) | 103 (65.6%) | 0.057* |
| | No | 10 (27.8%) | 12 (11.8%) | 27 (17.2%) | |
| | Don't Know | 3 (8.3%) | 10 (9.8%) | 27 (17.2%) | |
| **Doctor is liable only for those which are a consequence of a breach of his/her duty** | Agreed | 27 (75%) | 82 (80.4%) | 132 (84.1%) | 0.409** |
| | Disagreed | 9 (25%) | 20 (19.6%) | 25 (15.9%) | |
| **Doctor is liable for the negligence of his/her junior staff** | Agreed | 25 (69.4%) | 78 (76.5%) | 125 (79.6%) | 0.669** |
| | Disagreed | 11 (30.6%) | 24 (23.5%) | 32 (20.4%) | |
| **The hospital and not the doctor is liable for the negligence of its employee in case of a Government or private hospital** | Agreed | 22 (61.1%) | 55 (53.9%) | 90 (57.4%) | 0.817** |
| | Disagreed | 14 (38.9%) | 47 (46.1%) | 67 (42.6%) | |
| **Duty of the doctor to warn his/her patient of the risk inherent even under emergency situation** | Agreed | 33 (91.7%) | 87 (85.3%) | 123 (78.3%) | 0.331** |
| | Disagreed | 3 (8.3%) | 15 (14.7%) | 34 (21.7%) | |
| **In a mishap of a minor case, beneficiaries are both child and parents/guardian** | Agreed | 24 (66.7%) | 57 (55.9%) | 71 (45.2%) | 0.100** |
| | Disagreed | 12 (33.3%) | 45 (44.1%) | 86 (54.8%) | |
| **In case you diagnose the patient with AIDS, can you refuse the patient for treatment?** | Yes | 2 (5.6%) | 12 (11.8%) | 17 (10.8%) | 0.078** |
| | No | 33 (91.6%) | 84 (82.4%) | 132 (84.1%) | |
| | Don't Know | 1 (2.8%) | 6 (5.8%) | 8 (5.1%) | |
| **In case a patient is not well dressed (e.g.: torn clothes, revealing clothes, dirty clothes), can you refuse treatment?** | Yes | 9 (25.0%) | 5 (4.9%) | 5 (3.3%) | 0.000* |
| | No | 26 (72.2%) | 93 (91.2%) | 134 (85.5%) | |
| | Don't Know | 1 (2.8%) | 4 (3.9%) | 18 (11.2%) | |

* Significant, ** Non-significant

***Table 4.*** *Consent in daily practice.*

| Questions | Responses | BDS faculty | MDS faculty | Postgraduate students | p value |
|---|---|---|---|---|---|
| **Type of consent obtained from an illiterate patient** | Verbal Consent | 0 (0%) | 2 (2.0%) | 5 (3.2%) | 0.279** |
| | Patient's thumbprint | 16 (44.4%) | 31 (30.4%) | 49 (31.2%) | |
| | Relative signature | 3 (8.3%) | 2 (2.0%) | 8 (5.1%) | |
| | Verbal consent and thumbprint | 17 (47.3%) | 67 (65.6%) | 95 (60.5%) | |
| **For a patient under 15 years of age, consent for examination is taken from** | Patient | 3 (8.3%) | 12 (11.8%) | 28 (17.8%) | 0.529** |
| | Parent/Guardian | 32 (88.9%) | 82 (80.4%) | 119 (75.8%) | |
| | Classmate | 1 (2.8%) | 8 (7.8%) | 10 (6.4%) | |
| **Situations where consent may not be obtained** | Child | 11 (30.6%) | 28 (27.5%) | 38 (24.2%) | 0.688** |
| | Disabled individuals | 19 (52.8%) | 58 (56.9%) | 84 (53.5%) | |
| | Immigrants | 6 (16.6%) | 16 (15.6%) | 35 (22.3%) | |
| **What should be done to informed consent form after treatment is over?** | Given to patient | 3 (8.3%) | 3 (2.9%) | 7 (4.5%) | 0.589** |
| | Preserved | 32 (88.9%) | 91 (89.2%) | 142 (90.5%) | |
| | Discarded | 1 (2.8%) | 8 (7.9%) | 8 (5.0%) | |
| **Do you provide a copy of the consent form to the patient?** | Willingly | 21 (58.3%) | 39 (38.3%) | 68 (43.3%) | 0.379** |
| | Ask for the reason | 14 (38.9%) | 55 (53.9%) | 81 (51.6%) | |
| | Refuse | 1 (2.8%) | 8 (7.8%) | 8 (5.1%) | |

** Non-significant

act among 146 subjects [15]. This may be attributed to the fact that with the increase in knowledge, awareness also increases.

In the present study, awareness level about CPA was higher in females than males. It was also observed that professionals with increased numbers of experience in dentistry were more aware of consumer protection act. This may be due to

the fact that the expanding patient population is becoming more knowledgeable and aware of their rights, consequently taking action by contacting the consumer forum to lodge their complaints. Thus, dentists are also updating themselves to provide efficient dental care.

Consent forms an integral part of patient treatment and management. In this study, approximately 90% of the dentists take consent from their patients prior to the start of any treatment procedure and the type of consent on which they rely is informed consent. This is similar to the study done in Karnataka, India in which 90.7% of dentist in private practice as compared to 69.2% of dentists in teaching institutions take regular consent from their patients [16]. In another study done in Spain, written document of informed consent was absent in 40 cases, although the verbal information supplied was considered adequate in 14 cases [17].

The increased number of compensation cases brought against doctors has become a major concern throughout the world [18-21]. The most common dental specialty that patients complain about differs from one country to another. In USA, oral surgery claims grew from 18.8% in 1988 to 31.8% in 1991 [13]. In Washington state, parasthesia following surgical extraction of mandibular third molars accounted for nearly 25% of the claims in 1984 [22]. On the other hand, prosthodontics was most frequently involved in malpractice cases in Sweden. In a study of all Swedish disciplinary cases on dental malpractice between 1947 and 1983, 54.5% concerned mainly prosthodontic treatment [23,24]. In Turkey, most of negligence was caused during surgical intervention [25]. In Tehran, the majority of complaints were in fixed prosthodontics and oral surgery [7]. In Denmark, after crown & bridge treatment (23%), endodontic treatment was the next frequent malpractice claim (13.7%) [26].

If any patient suffers from symptoms as a result of treatment received from dental professionals, a claim for compensation could be carried out. In the present study, it was surprising to see that few participants were aware of the maximum compensation that could be claimed by the consumers. Dental compensation in comparison to medical compensation is low in amount. In the literature, dental compensation as low as 17 USD (for ill-fitting denture) to as high as 3423 USD (to a patient who died with a dental problem) has been granted under consumer protection act [16]. Similarly, awareness regarding the maximum time period within which a patient can sue the concerned doctor with evidence was found to be low among the participating dentists. This indicates the lack of complete understanding about the law among the dentists.

Hippocratic Oath says "I will treat without exception all who seeks my ministrations". Ethical rules presented by DCI (Dental Council of India) also emphasize on the same. However, still 27.8% of BDS faculty and 17.2% of postgraduate students said that patient has no right to sue a doctor if rejected emergency treatment. Even 25% of BDS faculty and 19.6% of MDS faculty disagreed that the doctor is liable for mishaps which are a consequence of a breach of his/ her duty.

The limitation of the present study was that equal number of sample was not taken from all the three professional groups selected in the survey.

## Conclusion

Considering the present scenario, MDS faculty dental professionals have more awareness of consumer protection act compared to other dental professionals.

So, we must upgrade our knowledge on consumer protection act at all levels of our profession and change our attitude by inculcating a practice to spread the message of consumer protection act for delivering quality dental care.

Dental and medical councils should utilize their capacity more observantly and strictly so that it will help in designing the law and legal processes, primarily for serving the society and secondarily for the benefit of the professionals. Therefore, faculty dental professionals need to update their understanding on consumer protection act and its amendments to be on a legally safer side.

## Acknowledgement

We acknowledge and thank all the dental schools and the participating dental professionals for participating in this study. The names of dental schools are not enumerated due to confidential reasons.

## Funding

No external funds were allocated for this study.

## Contribution of each author

SP coordinated all aspects of this study and assisted in proof reading.

IM edited and reviewed the manuscript.

CD planned the study, collected data from the study group, the analysis and interpretation of the data, and writing the manuscript.

RA assisted in data collection and writing the manuscript

## Conflict of Interests

As far as is known, there was no conflict of interest for any of the authors.

## References

1. Ammar W, Guile E. A one-year survey of dental malpractice claims in Riyadh. *Saudi Dental Journal*. 2000; **12**: 95-99.

2. Sharma A, Chhabra A, Bopiah C. Patient Consent in Dentistry: Are we Legally Safe? *Journal of Oral Health and Community Dentistry*. 2011; **5**: 68-72.

3. Kohli A. Medical consent in India – ethical and legal issues. *Internet Journal of Forensic Medicine and Toxicology*. 2007; **8**: 19.

4. Krishnan NR, Kasthuri AS. Informed Consent. Medical *Journal Armed Forces India*. 2007; **63**: 164-166.

5. Patil AM, Anchinmane VT. Medicolegal aspects of consent in clinical practice. *Bombay Hospital Journal*. 2011;

**53**: 203-208.

6. Yadwad BS, Gouda H. Consent - Its Medico Legal Aspects. *Journal of Association of Physicians of India* 2005; **53**: 891-894.

7. Kiani M, Sheikhazadi A. A five-year survey for dental malpractice claims in Tehran, Iran. *Journal of Forensic* and *Legal Medicine*. 2008; **16**: 76-82.

8. Acharya AB, Savitha JK, Nadagoudar SV. Professional negligence in dental practice: potential for civil and criminal liability in India. *Journal of Forensic Dental Sciences*. 2009; **1**: 2-7.

9. Shetty S, Singh K, Bhat N, Sharda A, Agarwal A, Chaudhary H. Awareness of consumer protection act among doctors in Udaipur city, India. *Journal of Dentistry* (*Tehran*). 2010; **7**: 19-23.

10. Griangrego E, Johnson B, Dwyer B. Emphasis: the liability issue. Protecting the profession. *Journal of American Dental Association*. 1986; **112**: 607-617.

11. Gordon B. The dentists as a defendant. *New York State Dental Journal*. 1986; **6**: 602-606.

12. Rudov MH, Myers T, Mirabella A. Medical malpractice insurance claims files closed in 1970. In: Appendix, Report of the secretary's commission on medical malpractice, Department of Health, Education and Welfare: Washington DC; 1973.

13. Milgrom P, Fiset L, Whitney C, Conrad D, Cullen T, O'Hara D. Malpractice claims during 1988-1992: a national survey of dentists. *Journal of American Dental Association*. 1994; **125**: 462-469.

14. Mellor AC, Milgrom P. Prevalence of complaints by patients against general dental practitioners in greater Manchester. *British Dental Journal*. 1995; **178**: 249-253.

15. Ramya S, Ravuri K, Harshvardhan A, Rajalakshmi S, Acharya S, et al. Be Aware or Beware! Awareness of COPRA (Consumer Protection Act). *Journal of Indian Association of Public Health Dentistry*. 2009; **13**: 25-29.

16. Aradhya S, Sikka M, Anup N, Kumar R, Sharma V, et al. Consumer Protection Act - Are we Aware? International *Journal of Medical and Dental Sciences*. 2009; **1**: 19-29.

17. Lopez-Nicolas M, Falcón M, Perez-Carceles MD, Osuna E, Luna A. Informed consent in dental malpractice claims. A retrospective study. *International Dental Journal*. 2007; **57**: 168-172.

18. Conrad DA, Whitney C, Milgrom P, O'Hara D, Ammons R, Fiset L, Vesneski W. Malpractice premiums in 1992: results of a national survey of dentists. *Journal of American Dental Association* 1995; **126**: 1045-1056.

19. Ventä I, Lindqvist C, Ylipaavalniemi P. Malpractice claims for permanent nerve injuries related to third molar removals. *Acta Odontologica Scandinavica*. 1998; **56**: 193-196.

20. Clark N, Paquin N, Nevin J. Dental malpractice: baseline data from insurance claims closed in 1970, with analysis. *Public Health Reports*. 1984; **99**: 87-93.

21. Doyal L, Cannell H. Informed consent and the practice of good dentistry. *British Dental Journal*. 1995; 178: 454-460.

22. Swanson AE. Removing the mandibular third molar: neurosensory deficits and consequent litigation. *Journal of Canadian Dental Association*. 1989; **55**: 383-386.

23. René N, Owall B. Malpractice reports in prosthodontics in Sweden. *Swedish Dental Journal*. 1991; **15**: 205-217.

24. Sjöström O. No-fault-compensation, patient guarantee, peer review committees: the Swedish experience. *International Dental Journal*. 1990; **40**: 103-108.

25. Ozdemir MH, Saracoglu A, Ozdemir AU, Ergonen AT. Dental malpractice cases in Turkey during 1991-2000. *Journal of Clinical Forensic Medicine*. 2005; **12**: 137-142.

26. Bjørndal L, Reit C. Endodontic malpractice claims in Denmark 1995-2004. *International Endodontics Journal.* 2008; **41**: 1059-1065.