

# Consent – a new era begins

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## IN BRIEF

- Provides an understanding of consent in general dental practice.
- Explains updates on a new legal case that changes the emphasis of the consent process.
- Updates readers on the quality of information that is required to obtain valid consent.

The law in relation to consent has changed following the handing down of the Supreme Court judgement in *Montgomery vs Lanarkshire* in March this year. Legally, clinicians, including dentists, must now take reasonable care to ensure that patients are aware of any material risks involved in a proposed treatment and of reasonable alternatives. This case now brings the law in relation to the disclosure of risks when obtaining consent to treatment in line with the guidance issued by regulatory bodies such as the GMC and GDC.

## INTRODUCTION

The law in relation to consent has changed following the handing down of the Supreme Court judgement in *Montgomery vs Lanarkshire Health Board*<sup>1</sup> in March this year.

Legally, clinicians, including dentists, must now take reasonable care to ensure that patients are aware of any material risks involved in proposed treatment and of reasonable alternatives. This case now brings the law in relation to the disclosure of risks when obtaining consent to treatment in line with the guidance issued by regulatory bodies, that is, the GMC and GDC.

## THE FACTS OF THE CASE

In 1999, Nadine Montgomery was pregnant with her first child. As a Type 1 insulin dependent diabetic, expectant mother, there was a risk of her carrying a large baby, as women with diabetes are likely to have babies that are larger than normal and there can be a particular concentration of weight on the babies' shoulders. This brings a risk of shoulder dystocia, a complication arising when the shoulders of the baby get stuck behind the pelvis during normal delivery, the risk being in the region of 9–10% in diabetic mothers.

Shoulder dystocia during delivery carries risks to the mother (in 11% of cases there is post-partum haemorrhage and in 3.8% of

cases there is fourth degree perineal tear) and to the baby. Seventy percent of cases of shoulder dystocia can be dealt with by the 'McRoberts' manoeuvre, but the manoeuvres used can cause shoulder and brachial plexus injury to the baby. The risk of brachial plexus injury is 0.2%. In some cases, shoulder dystocia causes the umbilical cord to be trapped, causing hypoxia and cerebral palsy, the risk of this being less than 1%.

During her ante-natal care, Mrs Montgomery raised concerns about standard delivery but her obstetrician did not warn her of the risks of shoulder dystocia, nor of any other risks that normal delivery carried. The obstetrician's rationale was that although there was a 9–10% risk of shoulder dystocia (and it was accepted that this was a high risk), the risk of a grave problem resulting from shoulder dystocia was very low. The obstetrician explained during evidence that '*if you were to mention shoulder dystocia to every [diabetic] patient, if you were to mention to any mother who faces labour that there is a very small risk of the baby dying in labour, then everyone would ask for a caesarean section, and it's not in the maternal interests for women to have caesarean sections*'.<sup>2</sup> The Court ultimately did not like or accept this approach.

There was difficulty in delivering the baby as a result of shoulder dystocia and during the 12 minutes it took to free him he was starved of oxygen as the umbilical cord became occluded. The baby was born with cerebral palsy and suffered the loss of the use of his arm – a further complication of the brachial plexus injury sustained during the birth.

Mrs Montgomery raised an action alleging clinical negligence in the Court of Session in

Edinburgh and argued that had she known of the 10% risk of shoulder dystocia, she would have asked for a caesarean section. The case was initially decided in favour of the defenders and an appeal to the Inner House of the Court of Session also failed. Mrs Montgomery therefore appealed the UK Supreme Court, based in London, which is the final court of appeal in the UK for civil cases, and for criminal cases from England, Wales and Northern Ireland.

## ANALYSIS OF THE JUDGEMENT AND THE PREVIOUS CASE LAW

The Supreme Court, sitting with seven judges instead of the usual five, allowed the appeal and Mrs Montgomery was awarded £5.25 million in damages. In their analysis of the facts of the case, the Supreme Court considered the pre-existing case law in relation to disclosure of risks and the standard of care.

In Scotland, the legal test when alleging negligence stems from the case of *Hunter vs Hanley*,<sup>3</sup> which applies a three-stage test in order for breach of duty to be established. Firstly, it must be proved that there is a usual and normal practice. Secondly, it must be shown that the clinician did not adopt that practice. Thirdly, it must be proven that the course adopted by the clinician, is one that no clinician of ordinary skill would have taken if acting with ordinary care. The *Hunter vs Hanley* test was then adopted in England in 1957 in the *Bolam* case,<sup>4</sup> in which it was established that a doctor is not guilty of negligence if acting in accordance with a practice accepted as proper by a responsible body of medical practitioners.

Various cases since then have applied the principles of *Bolam* and *Hunter vs Hanley*

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to claims concerning consent to treatment. In the case of *Sidaway*,<sup>5</sup> the court applied the Bolam test to the issue of disclosure of risks when obtaining consent to treatment, although the court in *Sidaway* did indicate that there could be a situation in which the proposed treatment carried with it such grave risks that no prudent medical man would fail to warn of the risk. However, to all intents and purposes, the Bolam test was affirmed in relation to disclosure of risks. *Sidaway* was then followed in Scotland in the case of *Moyes vs Lothian Health Board*<sup>6</sup> in which Lord Caplan said:

*'In my view the Sidaway case in no way alters the pre-existing view of the law that the appropriate tests to apply in medical negligence cases are to be found in Hunter vs Hanley and Bolam.'*

However, the Australian case of *Rogers vs Whitaker*<sup>7</sup> took a different approach in 1992 and, in that case, a clinician was found to be in breach of duty for failing to disclose the risk of total blindness to a patient who was already blind in one eye. This was perhaps a sign that the tide was turning, from the early 'doctor knows best' approach, through the responsible body of medical opinion test, to the specific patient approach which has now been stated in the *Montgomery* case. Bolitho,<sup>8</sup> in 1998, then emphasised that the medical profession does not solely dictate the standard of care of a doctor and that a judge is the final decision maker.

Until *Montgomery*, the test to be applied when disclosing risks was that of the prudent doctor/clinician and the tests laid out in *Bolam* and *Hunter vs Hanley*. That has now been overturned by the *Montgomery* case which overturned the decision made in *Sidaway*.

What the judges in *Montgomery* said was that the extent of information given to a patient about the risks of a proposed treatment is not to be determined by the clinician or what other clinicians in the same situation would do. Rather the test is what the particular patient sitting in front of the clinician wants to know. Patients must be told of material risks. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the clinician is or should reasonably be aware that the particular patient would be likely to attach significance to it.

## IMPLICATIONS FOR DENTISTRY

What does this mean for dentists? In reality it changes professional practice very little and the *Montgomery* case simply brings

the law into line with the ethical requirements imposed by the regulatory bodies, including the GDC. This has been the GDC position in *Standards for the Dental Team* since September 2013. However, the earlier GDC guidance and the GDC booklet on *Principles of Patient Consent* also required dentists to 'find out what your patients want to know as well as telling them what you think they need to know.'<sup>9</sup> Dentists need to be fully familiar with the precise wording of *Standards for the Dental Team* and be aware of this legal case.

The requirement is that a dentist, in respect of consent, should tell the patient everything they want to know as well as everything the dentist thinks they might need to know. You might be forgiven for thinking that this has a mystic clairvoyant feel about it and you may not be far wrong. The intention is of course that the information asymmetry that exists in any professional relationship is levelled by the duty on the dentist to ensure that the patient has sufficient information to make an informed choice about what they want done to their bodies.

The obstetrician stated that had Mrs *Montgomery* asked her 'specifically about exact risks' she would have advised her of the risk of shoulder dystocia. A patient cannot be expected to know what questions to ask the clinician or to understand all of the implications of a procedure without expressly being informed about these or about alternatives. That is why they rely and trust the dentist in the first place. Equally important is the conclusion that the percentage risk of a situation occurring should not be the sole determinant of the disclosure of that risk to the patient. There are many percentages in clinical dentistry for example, in the case of loss of vitality after crown preparation or in relation to the success of root canal treatment. The significance of a given risk is likely to reflect a variety of factors besides its magnitude; for example, the nature of the risk, the effect which its occurrence would have upon the life of the patient, the importance to the patients of the benefits sought to be achieved by the treatment, the alternatives available and the risks involved in those alternatives.<sup>10</sup>

Thus simply quoting a percentage risk without putting it into the context of the patient's own views is insufficient.

The *Montgomery* judgement will perhaps require a little more time, effort and judicious questions being asked by the dentist to establish what is important to the patient and to ascertain what emphasis would need to be placed on any possible risk to them specifically. Depending on the setting of the

care this may be more challenging when insufficient time is available to have these discussions. The prudent dentist should also record in detail the treatment options and risks discussed with the patient.

Where a patient does not wish to be informed of the risks and prefers not to discuss the matter at all then the clinician is not obliged to have these discussions.<sup>11</sup>

How we communicate those risks to patients or describe treatments is a significant part of the consent process. What emphasis should be placed on each of the risks and how determinative will it be in influencing a patient? There are risks for all dental procedures. Looking at root canal treatment of a heavily restored upper molar tooth *vs* extraction will elicit many risks that final year dental students would be able to list in graphic detail. Indeed that is sometimes the very issue when obtaining consent. How much we tell patients about how the treatment is carried out, with a list of every possible option with their complications, sequelae and management of the complications can be influential and 'too much in the way of information may only serve to confuse or alarm the patient'. The *Montgomery* case resolutely rejects this idea of paternalism and the notion that the clinician alone should decide what should be disclosed to patients.

## CONCLUSION

The *Montgomery* case clarifies that clinicians must recognise a patient's legal and ethical right to autonomy and informed choice and sweeps away any notion that doctor (or dentist) knows best. Patients must be fully informed about the risks to them that any procedure carries and be permitted to decide whether to proceed at all or whether they wish to pursue alternative options or no treatment at all.

It is for the profession now to determine, clinical area by clinical area, what the risks that ought to be disclosed are and then it is for the individual clinician to decide what emphasis they need to place on those risks to the particular patient they have in their dental chair.

The moral of the story for dentists is that it is prudent to get to know your patients so that you can discuss with them risks that any patient would want to know, plus any risks that you would consider would be relevant to the particular patient concerned. In order to be able to satisfy the latter requirement, patients need to be asked if there is anything of particular relevance to them that they would want to know. The clinician's advice must be both 'fact sensitive and sensitive also to the characteristics of the patient.'<sup>13</sup>

1. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104.
2. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104 paragraph 13.
3. Hunter v Hanley [1955] SC 200.
4. Bolam v Friern Hospital Management Committee 1957 1 WLR 582.
5. Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] UKHL 1.
6. Moyes v Lothian Health Board [1990] SLT 444.
7. Rogers v Whitaker [1992] HCA 58.
8. Bolitho v City and Hackney Health Authority 1998 AC 232.
9. General Dental Council. Principles of patient consent. 2005. Online information available at <http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/PatientConsent%5B1%5D.pdf> (accessed June 2015).
10. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104 paragraph 89.
11. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104 paragraph 85.
12. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104 paragraph 33.
13. Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC 104 paragraph 89.

## Erratum

*BDJ* 2015; 218: 609–660 (Issue 11)

The following digital object identifier (DOI) numbers associated with articles in issue 11 were incorrect in the original issue as published on the 12 June 2015. We apologise for any inconvenience caused by this error.

In Stephen Hancocks, Right handedness, *BDJ* 2015; 218: 609, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.398. The correct number is 10.1038/sj.bdj.2015.477

In C. M. Murray & N. P. Chandler, Magnification: Magnifying the point, *BDJ* 2015; 218: 610, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.399. The correct number is 10.1038/sj.bdj.2015.478

In P. Ramsay-Baggs, Good practice: The gloves are on, *BDJ* 2015; 218: 610, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.400. The correct number is 10.1038/sj.bdj.2015.479

In H. Gayathri & B. Madhan, Case report: Malingering and factitious disorders, *BDJ* 2015; 218: 610, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.401. The correct number is 10.1038/sj.bdj.2015.480

In D. Howarth, Fluoride varnish: Coating over FV, *BDJ* 2015; 218: 610–611, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.402. The correct number is 10.1038/sj.bdj.2015.481

In R. W. Mills, Safeguarding children, *BDJ* 2015; 218: 610, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.403. The correct number is 10.1038/sj.bdj.2015.482

In Letter (BDJ 2015; 215: 556–557), *BDJ* 2015; 218: 611, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.404. The correct number is 10.1038/sj.bdj.2015.483

In C. D. Stephens, Orthodontics: Getting straight to orthodontic relapses, *BDJ* 2015; 218: 611, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.405. The correct number is 10.1038/sj.bdj.2015.484

In Children's dental health – a mother's perspective, *BDJ* 2015; 218: 612–613, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.406. The correct number is 10.1038/sj.bdj.2015.485

In Failure to include dentistry in health hurting patients and taxpayers, *BDJ* 2015; 218: 613, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.407. The correct number is 10.1038/sj.bdj.2015.486

In New CDO announced, *BDJ* 2015; 218: 614, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.408. The correct number is 10.1038/sj.bdj.2015.487

In Be clear on costs, dentists urged, *BDJ* 2015; 218: 614, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.409. The correct number is 10.1038/sj.bdj.2015.488

In A day in the life: 12 people. Eight days. One goal, *BDJ* 2015; 218: 614–615, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.410. The correct number is 10.1038/sj.bdj.2015.489

In BDA and BDIA announce new 'Strategic Partnership', *BDJ* 2015; 218: 616, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.411. The correct number is 10.1038/sj.bdj.2015.490

In BDIA launches its 'Code of Practice for Dental CPD', *BDJ* 2015; 218: 616, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.413. The correct number is 10.1038/sj.bdj.2015.491

In Bringing first smiles to children, *BDJ* 2015; 218: 616, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.412. The correct number is 10.1038/sj.bdj.2015.492

In Book review: Cone beam computed tomography in orthodontics: indications, insights and innovations, *BDJ* 2015; 218: 617, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.414. The correct number is 10.1038/sj.bdj.2015.493

In Book review: Mosby's orthodontic review, *BDJ* 2015; 218: 617, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.415. The correct number is 10.1038/sj.bdj.2015.494

In Book review: Dentine hypersensitivity: Developing a person-centred approach to oral health, *BDJ* 2015; 218: 617, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.416. The correct number is 10.1038/sj.bdj.2015.495

In M. H. Thornhill *et al.*, NICE and antibiotic prophylaxis to prevent endocarditis, *BDJ* 2015; 218: 619–621, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.392. The correct number is 10.1038/sj.bdj.2015.496

In J. C. Williams *et al.*, Who wears the braces? A practical application of adolescent consent, *BDJ* 2015; 218: 623–627, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.393. The correct number is 10.1038/sj.bdj.2015.497

In J. M. Martin-Kerry *et al.*, Practical considerations for conducting dental clinical trials in primary care, *BDJ* 2015; 218: 629–634, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.397. The correct number is 10.1038/sj.bdj.2015.498

In J. Radford, Commentary: Effect of beverages on color and translucency of new tooth-colored restoratives, *BDJ* 2015; 218: 635, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.417. The correct number is 10.1038/sj.bdj.2015.499

In J. Radford, Commentary: Choosing wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine, *BDJ* 2015; 218: 635, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.418. The correct number is 10.1038/sj.bdj.2015.500

In J. Radford, Commentary: Management of severe acute dental infections, *BDJ* 2015; 218: 635, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.419. The correct number is 10.1038/sj.bdj.2015.501

In J. Radford, Commentary: Infiltration and sealing versus fluoride treatment of occlusal caries lesions in primary molar teeth. 2–3 years results, *BDJ* 2015; 218: 635, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.420. The correct number is 10.1038/sj.bdj.2015.502

In S. Wright & C. Archer, An exploratory study to investigate if patients are able to aid the early diagnosis of peri-implant complications, *BDJ* 2015; 218: 637–640, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.394. The correct number is 10.1038/sj.bdj.2015.503

In M. Ross & S. Turner, Direct access in the UK: what do dentists really think?, *BDJ* 2015; 218: 641–647, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.395. The correct number is 10.1038/sj.bdj.2015.504

In S. Kotecha *et al.*, A multicentre audit of GDPs knowledge of orthodontic retention, *BDJ* 2015; 218: 649–653, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.396. The correct number is 10.1038/sj.bdj.2015.505

In Supporting dental healthcare professionals, *BDJ* 2015; 218: 657, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.421. The correct number is 10.1038/sj.bdj.2015.506

In All smiles, *BDJ* 2015; 218: 657, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.422. The correct number is 10.1038/sj.bdj.2015.507

In Results every time, *BDJ* 2015; 218: 657, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.423. The correct number is 10.1038/sj.bdj.2015.508

In It's an easy life with efficient technology, *BDJ* 2015; 218: 658, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.424. The correct number is 10.1038/sj.bdj.2015.509

In Get connected, *BDJ* 2015; 218: 658, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.425. The correct number is 10.1038/sj.bdj.2015.510

In A dental chair for you, *BDJ* 2015; 218: 658, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.427. The correct number is 10.1038/sj.bdj.2015.511

In The first purely ceramic-based restorative material, *BDJ* 2015; 218: 658, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.426. The correct number is 10.1038/sj.bdj.2015.512

In Extremely small and lightweight, *BDJ* 2015; 218: 659, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.428. The correct number is 10.1038/sj.bdj.2015.513

In Safer, easier, cheaper, *BDJ* 2015; 218: 659, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.429. The correct number is 10.1038/sj.bdj.2015.514

In Helpful convenience for orthodontic patients, *BDJ* 2015; 218: 659, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.430. The correct number is 10.1038/sj.bdj.2015.515

In Dental care with extracts of ginger and curcuma, *BDJ* 2015; 218: 659, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.431. The correct number is 10.1038/sj.bdj.2015.516

In The next generation superbug beating technology has arrived, *BDJ* 2015; 218: 660, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.432. The correct number is 10.1038/sj.bdj.2015.517

In Total patient comfort, *BDJ* 2015; 218: 660, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.435. The correct number is 10.1038/sj.bdj.2015.518

In Maximising your potential, *BDJ* 2015; 218: 660, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.433. The correct number is 10.1038/sj.bdj.2015.519

In Incorporating technology could be easier than you think, *BDJ* 2015; 218: 660, the DOI was incorrectly stated as 10.1038/sj.bdj.2015.434. The correct number is 10.1038/sj.bdj.2015.520