Consent – an update

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In brief

Provides an overview of the Montgomery case in relation to the law on consent in the UK and the existing professional and ethical guidance from the General Dental Council.

Shows how subsequent court cases have interpreted and clarified some aspects of the Montgomery judgement.

Details what dentists and their teams can do to improve the consent process in practical ways.

Following the judgement in Montgomery in March 2015 which brought the law of consent up to speed with what the GDC 's ethical and professional guidance expected registrants to do, this article looks at how other cases have interpreted Montgomery subsequently and the impact and implications for dentists. The importance of excellent communication is emphasised in order to provide sufficient and relevant information to the particular patient you have sitting in your dental chair.

Introduction

In March 2015 the judgement of the Supreme Court in the case of Montgomery *v* Lanarkshire Health Board was a significant evolution in the way that the courts approach the issue of consent in relation to clinical negligence claims.[1] There was a very real possibility that the floodgates of claims in relation to consent would open as a result. This article considers the impact of the judgement on the dental profession and examines some of the legal authorities following Montgomery and how the law in relation to consent has developed.

Before Montgomery, as a matter of law, the extent of information that needed to be given to a patient in order to obtain valid consent was principally determined by reference to what other clinicians in the same situation would do. This dated back to the Bolam case[2] some sixty years previously and was well understood by most dentists. However, in the judgement of the Supreme Court in Montgomery, the law had ceased to reflect the reality and complexity of the way in which healthcare services were provided or the way in which providers and recipients of such services viewed their relationship.

In the view of the Court, patients had become largely regarded as persons holding rights (rather than as passive recipients of medical care) and were being widely treated as consumers exercising choices. The court noted that these developments in society had been reflected in professional practice as indicated in:

1. The General Medical Council (GMC) document, *Good Medical Practice*, which specifies that one of the duties of a doctor registered with the GMC is to:
   '*Work in partnership with patients, listen to, and respond to, their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' rights to reach decisions with you about their treatment and care*'
2. The GMC's guidance in relation to consent,[3] which describes the basic model of partnership between a doctor and patient as follows:
   '*The doctor explains the options to the patient, setting out the potential benefits, risks, burdens and side effects of each option, including the option to have no treatment. A doctor may recommend a particular option which they believe to be best for the patient, but they must not put pressure on the patient to accept their advice. The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one*'.

In light of the above, the Court updated the common law in relation to consent so that test in this regard is no longer focused on what information other clinicians in the same situation would have disclosed to the patient and is directed instead on what information the particular patient sitting in your chair would want to know.

Standards

Montgomery was, of course, an obstetric case that was principally concerned with the medical profession. However, it is equally relevant to other healthcare providers, including dentists and other dental care professionals, and the standards of the General Dental Council (GDC) in relation to consent are very similar to those of the GMC, set out well before the judgement in Montgomery was handed down.

Standard 3.1 of Standards for the Dental Team states that 'You must obtain valid consent before starting treatment, explaining all the relevant options and the possible costs' and in accordance with Standard 3.1.3 this means that 'You should find out what your patients want to know as well as what you think they need to know'.

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Standard 3.2 also requires dental professionals to make sure that patients understand the decision they are being asked to make and, in accordance with Standard 3.2.2, this means that 'You must tailor the way you obtain consent to each patient's needs'.

In this context, it can be seen that the judgement in Montgomery has not resulted in any fundamental change to dentists' professional obligations. Rather it is a case of the law in relation to clinical negligence catching up with developments within the dental and medical professions. Montgomery did, however, reinforce the importance of discussing with the patient, before treatment, the options available to them (including the option of doing nothing) and the risks and benefits of each option.

This appears to create a significant responsibility on the dentist to find out, as part of the consent process, what is important to the particular patient sitting in their chair. Will they consider a risk of an instrument separating during root canal on their upper first molar more significant than another patient and will they therefore decline the treatment or seek a referral to a specialist. Unless you have this discussion how will you ever know?

In determining whether or not a dental practitioner has properly advised their patient in relation to the risks of any treatment option, the courts will look to determine whether, in all the circumstances of the case, the patient has been advised of the risks that are material to them. A number of cases since Montgomery have considered this issue and are discussed below.

Cases

In the case of A *v* East Kent Hospitals University NHS Foundation Trust[4] a claim was brought by the mother of a severely disabled child in relation to an alleged failure to warn her during pregnancy of the risk of her baby having a chromosomal abnormality when scans at 28 weeks and 31 weeks gestation showed that the baby was small. The mother claimed that had she been warned of the risk, she would have undergone an amniocentesis to confirm the situation and would have terminated her pregnancy if an abnormality had been found. She claimed for the costs of caring for her disabled child.

The mother's expert opined that on the basis of the scans undertaken at 28 and 31 weeks gestation, the risk of a chromosomal abnormality was 1–3%, whereas the Trust maintained that the risk was much less at 0.1%. The court preferred the Trust's evidence on the basis that very few fetuses with a chromosomal abnormality carry to term; the tests that had been carried out excluded the risk of the type of abnormality in this case to a background level; and the ultrasound scans had not detected the kind of structural abnormalities normally present in a foetus with a chromosomal abnormality. It was accepted that this risk was theoretical or negligible and, therefore, the medical staff had been entitled to conclude that placental insufficiency was the likeliest cause of the reduction in growth.

The court recognised that the importance of patient autonomy had been affirmed in Montgomery and that there was a duty to warn about material risks but not theoretical risks. In this case there was no evidence of there being a material risk of the child suffering from a chromosomal abnormality and therefore the Trust did not breach their duty of care to the mother by not mentioning it.

Why is this so important post Montgomery? One of the concerns was that dentists would now have to warn about every single risk about a particular procedure even if the risk was theoretical – for example taking a tooth out in the lower jaw could theoretically result in a dislocated jaw and most patients would think that was significant enough to be advised about. The judgement in this case suggests disclosing this theoretical risk is not necessary for the consent process, recognising the practical difficulties consultations with patients throw up.

In another obstetric case, Mahima Begum Tasmin *v* Barts Health NHS Trust,[5] it was alleged by the claimant that the senior registrar involved in her delivery had failed to recommend fetal blood sampling, which would likely have led to her being delivered by caesarean section, and that her mother had not therefore validly consented to persevering with the labour, which was the cause of her birth-related injuries. The court held that fetal blood sampling should have been offered but that the results would have likely been normal and would not therefore have led to delivery by caesarean section. Accordingly, the risk of not undertaking foetal blood sampling was negligible and therefore immaterial. In the circumstances, the registrar did not fail to obtain informed consent when she recommended that the mother persevere with labour.

An application in dentistry might be the suggestion that a certain type of test or imaging might influence a treatment decision which is clearly valid, but if that test would not, had it been done, change the planned care provided, the consent given would be considered to be valid.

In David Spencer *v* Hillingdon Hospitals NHS Trust,[6] the claimant alleged that he had not been appropriately advised of the risks of a thrombosis or embolism. Mr Spencer underwent surgery for an inguinal hernia, but then suffered a deep vein thrombosis (DVT), followed by a pulmonary embolism (PE) on each lung. It was alleged that the hospital staff failed to warn of the risk of a thrombosis or embolism and that the claimant had not been advised of the signs and symptoms, or the importance of seeking medical help, should these symptoms arise.

Having considered Montgomery, it was held that medical professionals have a duty of care to advise and inform patients of anything which the ordinary sensible patient would be justifiably aggrieved at not being told about when fully appraised of its significance. The ordinary sensible patient would expect to have been warned of the risks of these conditions eventuating, even when the risk was low (0.7% for DVT and 0.9% for PE) and would have felt justifiably aggrieved to have not been properly advised on discharge if he had been told about the significance of such information. Although the risk was small in many cases, it was held that the Trust breached their duty of care to the claimant by failing to advise him of the life-threatening significance of the symptoms of the kind he suffered and the consequent need for him to urgently seek medical care if such symptoms arose and he won his case. An issue that was considered in this case was whether the patient had responsibility to inform his GP and the hospital of the pain in his calves which were a sign of DVT. Had he alerted them to this they could have intervened earlier to obviate the subsequent problems that became the basis of the claim. This aspect of contributory negligence was rejected in this case by the judge.

In the case of Crossman *v* St George's Healthcare NHS Trust,[7] the court considered matters relating to the discussion that is required with a patient in order to obtain valid consent. In this case, treatment had been sought by the claimant for minor compression of his spinal cord. The potential risks and benefits of surgery were discussed but conservative treatment was ultimately recommended. The claimant was nonetheless placed on the waiting list for surgery and when he queried whether there had been a mistake, was told that he would be put to the end of the waiting list if he did not attend his pre-operative appointments.

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The claimant was subsequently admitted for surgery and although he was advised to delay the operation because of unrelated issues, he opted to proceed. The surgery was performed non-negligently. However, the claimant suffered a nerve root injury as a result of the operation.

One of the issues that needed to be considered by the court was whether the claimant was partly responsible for the failure to follow the conservative management plan that had been recommended. The court acknowledged that, post-Montgomery, there was a much greater emphasis on the importance of a doctor's duty to involve the patient in decisions relating to treatment. However, it was acknowledged in Montgomery that an approach which required a patient to question his or her doctor would be unrealistic and the court regarded it as understandable that, when Mr Crossman was told that he would go to the back of the queue if he did not keep his appointment, he accepted that he was being prepared for surgery, rather than questioning his doctor as to whether surgery was the correct option. The claimant's failure to question the change in treatment plan did not absolve the Trust of its responsibility for erroneously changing the treatment plan and he was awarded £92,500.

This case serves not only as a warning in relation to the care that is required when departing from a previously agreed treatment plan, but also as a reminder that practitioners cannot rely on their patients to disclose important information in the absence of appropriate questioning by the practitioner. Essentially, it is up to the practitioner to ask the relevant questions rather than rely on the patient to voluntarily disclose information. For example, if you don't ask if a tooth prepared for a crown has been sensitive to hot or cold, or painful during the temporisation stage you cannot assess the appropriateness of fitting the crown on with permanent cement at the fit appointment.

In the Scottish case of Inglis *v* Brand,[8] the claimant brought a claim against his dentist after developing neurological symptoms following a wisdom tooth extraction, alleging that he was inadequately informed before the extraction. The defendant maintained that, having determined that the claimant's lower left wisdom tooth could not be restored, she discussed with him the options of leaving the tooth *in situ* or extraction, but ultimately recommended the latter. The defendant stated that she advised the claimant that tooth extraction carried a risk of pain and a lesser risk of temporary or permanent numbness to the lower lip or tongue if the procedure converted to a surgical extraction or if the root put pressure on the nerve. The claimant, however, alleged that there had been no such discussion.

Applying Montgomery, the court confirmed that the defendant had a duty to advise the claimant of any material risks of the recommended treatment and any reasonable alternative treatment. The court accepted that the defendant had discussed the options of tooth extraction and doing nothing, had reasonably recommended tooth extraction and had adequately warned the claimant of the material risks associated with that procedure.

What is evident from these cases is that the courts do not expect dental or other healthcare professionals to warn patients of every conceivable risk. However, it is apparent that a one size fits all approach to consent will not be sufficient. What is a material risk to one patient will not be a material risk to another. Discussion with the patient will be required to identify what risks are material to them and the dentist is responsible for eliciting such information.

We are very much in the era of shared decision-making[9] where the patient should have an active part in their treatment options and delivery of care. Of course, because patients have considerable trust in their dentist, clinicians sometimes mistake this benevolent familiarity for blind acceptance of anything that is advised. Talk to the patient, actively listen to them, make sure they understand what is being offered and engage with their values and wishes. This is easier said than done in a time-poor NHS system, but a necessity nevertheless. It protects us from litigation and enriching lawyers and it protects the patients from treatment they may subsequently regret having had done.

There will, of course, be many instances in relation to basic dental treatment where the information that different patients will want and need to know will not vary significantly. However, dental professionals must be alert to those cases where the information that they would routinely give to patients will not suffice. An example of this is in relation to the extraction of teeth. Most patients will not need to be warned about the risk of developing medication related osteonecrosis of the jaw (MRONJ). Practitioners must, however identify patients who are taking relevant medication and provide them with the appropriate warning. Although the risk of developing MRONJ is small, it is not a theoretical risk for patients taking bisphosphonates for example as the consequences for them may be significant, and the risk may therefore be regarded as material.

Conclusion

In conclusion, Montgomery and subsequent cases have reinforced the professional principle that consent is a process that requires discussion with the patient covering all viable treatment options and all risks that would be material to that patient. In doing so, these cases have raised the bar that practitioners must meet in the defence of a claim against them for failing to obtain valid consent. Healthcare providers, including dentists, who do not discuss matters fully with their patients (or fail to make suitably detailed records of such discussions) risk falling short of this standard. It is recognised that the demands on a dentist's time can make it difficult to fulfil the requirements of obtaining valid consent. However, the benefits of doing so are evident from the above case of Inglis *v* Brand.

In November 2016 the Royal College of Surgeons published advice in relation to consent post-Montgomery, which is recommended further reading on this topic.

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4. Mrs A v East Kent Hospital University NHS Foundation Trust. 2015. EWHC 1038(QB).
5. Mahima Begum Tasmin v Barts Health NHS Trust. 2015. EWHC 3135.
6. David Spencer v Hillingdon Hospitals NHS Trust. 2015. EWHC 1058(QB).
7. Crossman v St George's Healthcare NHS Trust. 2016. EWHC 2878 (QB).
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