I'm not a robot

Surgical consent practice in the UK following the Montgomery ruling: A national cross-sectional questionnaire study. McKinnon C, Loughran D, Finn R, Coxwell-Matthewman M, Jeyaretna DS, Williams AP. McKinnon C, et al. Int J Surg. 2018 Jul;55:66-72. doi: 10.1016/j.ijsu.2018.05.016. Epub 2018 May 26. Int J Surg. 2018. PMID: 29775736 Feeling overwhelmed?Considering signing up at dipgwarrior.org so we can point you in the right direction. Learn more Sign-Up For Updates One basic principal of medical ethics is that no person should be included in any sort of experiment without his or her agreement. This agreement is called consent. In the past, heinous examples of medical experiments occurred where people were given injections of experimental drugs or even diseases without knowing it. However, since the Nuremburg trials in the 1940s and particularly since the 1970s, experimenting on people without their agreement and consent has been considered unacceptable in the U.S. and the rest of the civilized world. Informed consent refers to the idea that not only should people know they are in a clinical trial, but that they also must understand what will happen to them during the trial. Informed consent is a process that involves both talking to someone involved in running the trial to learn about the trial and signing a paper, called the consent form, that explains the trial. The process of informed consent should include: What is known about the experimental treatment. What will happen during the clinical trial, including what medicines will be taken, when and how they will be taken, and what and when tests or procedures will be done. What parts of the trial are considered standard, i.e., they would happen even if you are not involved in the trial, and what parts of the trial are experimental. Experimental parts of the trial can be treatments, office visits, tests, etc. What the alternative is to being in the trial and what the treatment and testing would be like if you do not participate in the trial. Whether there will be any financial costs to participate in the trial. Whether the trial is expected to benefit the participants personally or whether it is to benefit patients in the future. Whom to contact if you have questions or complaints about the trial. What the procedure is to stop participating in the trial. All clinical trials are overseen by an Institutional Review Board (IRB), which is a group of scientists and non-scientists that ensure that clinical trials are done in an ethical manner. Each university or cancer center has its own institutional review board. The institutional review board approves all aspects of clinical trials, including what is included in a consent form. The consent form should have contact information for the institutional review board in case you ever feel uncomfortable with what is happening in a clinical trial. Giving informed consent requires that someone has the mental capacity to understand his or her options and to make a rational and consistent choice. Some patients, such as children or people with mental impairments, are thought to need special protection because they may not understand enough to give informed consent. In that case, two things are needed. First, the person’s guardian, such as the parent for a child, must give informed consent. Second, if possible, the child or impaired person needs to agree to the trial, which is called giving assent. If possible, the child or impaired person needs to agree to the trial, which is called giving assent. Sometimes this is impossible, for example for young infants or people who cannot communicate. The age at which assent is required will vary from trial to trial, but national groups such as the American Academy of Pediatrics, and the Children’s Oncology Group recommend that children 7 years of age or older not be enrolled in clinical trials without their assent. Requiring assent allows a child to say no and to have some control over what happens to his or her body. Not only are uncooperative children difficult to get useful scientific results from, but some children may tire of participating in medical research before parents, who naturally hope for a miracle. The Motorsport Images Collections captures events from 1895 to today’s most recent coverage.Discover The CollectionCurated, compelling, and worth your time. 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Analysis BMJ 2017; 357 doi: (Published 12 May 2017) Cite this as: BMJ 2017;357:j2224 Sidaway v Bethlem Royal Hospital Governors [1985] WLR2 871. 1985.Bolam v Friern Hospital Management Committee [1957] WLR 1 582. 1957.Montgomery v Lanarkshire Health Board [2015] WLR 2 768. 2015.Bolitho v City and Hackney Health Authority [1998] AC 232. 1998.Pearce v United Bristol Healthcare NHS Trust [1999] ECC 167. 1999.Wyatt v Curtis [2003] EWCA Civ1779. 2003.Chester v Afshar [2004] WLR 3 927. 2004.Hopp v Lepp [1980] 2 SCR 192. 1980.Rebid v Hughes [1980]2 SCR 880. 1980.Rogers v Whitaker [1992] 109 AL 625. 1992.UK Government. Mental Capacity Act 2005. 2005. Available at (accessed July 2022).PH and A Local Authority v Z Limited & R [2011] EWHC 1704. 2011.A NHS Trust v X [2014] EWCOP 35. 2014.A Local Authority v TZ [2013] EWHC 2322. 2013.PC v City of York Council [2013] EWCA Civ 478. 2013.An NHS Trust v CS [2016] EWCOP 10. 2016.Wandsworth CGC v IA [2014] EWHC 990. 2014.British Medical Association. 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Analysis of fitness to practise case data for the General Dental Council. 2016. Available at (accessed July 2022).Dental Protection. Consent. 2016. Available at uk-excl-scotland).pdf (accessed July 2022).British Medical Association. Consent and refusal by adults with decision-making capacity. A toolkit for doctors. 2019. Available at (accessed July 2022).Chan S W, Tulloch E, Cooper E S, Smith A, Wojcik W, Normal J E. Montgomery and informed consent: where are we now? Br Med J 2017; DOI: 10.1136/bmj.j2224. In the case of A v East Kent Hospitals University NHS Foundation Trust4 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.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-making9 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.