CONSENT-

GETTING TO YES

PG Cert Dental Law and Ethics pre-reading

ABSTRACT

Overview of the law of consent in England with reference to dental practice

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CONSENT- GETTING TO YES

"Every person being of adult years and sound mind has a right to determine what shall be done with his own body"[1]

This is the starting point for consent, establishing the doctrine of autonomy (literally self rule) in which a patient is entitled to come to any decision about their treatment or refusal of treatment freely and independently. Whilst the dentist's role is to help a patient come to a decision by providing information and choices, ultimately the decision should be the patients alone.

This was not the original starting point since the Hippocratic Oath required doctors to avoid disclosure of any information to patients to save them the burden of choice or anxiety.

Perform [your duties] calmly and adroitly, concealing most things from the patient while you are attending to him.....turning his attention away from what is being done to him;....revealing nothing of the patient's future or present condition'

Recognising an individuals right of autonomy makes self-creation possible. It allows each of us to be responsible for shaping our lives according to our own coherent or incoherent-but in any case, distinctive-personality. It allows us to lead our lives rather than be led along them, so that each of us can be, to the extent a scheme of rights can make this possible, what we have made of ourselves.[2]

In extremis "Even when his or her life depends on receiving medical treatment, an adult of sound mind is entitled to refuse it" [3] In this case a woman who was 36 weeks pregnant was diagnosed with pre-eclampsia and was advised to be admitted to hospital to induce her delivery. Without this treatment her health and life and that of her baby were in real danger. Wanting a natural birth, she refused but, was against her will, transferred to a hospital and she was delivered of a baby girl by Caesarean section. This was deemed unlawful , amounted to trespass and denied her right of autonomy –"her right was not diminished merely because her decision to exercise it might appear morally repugnant"[3]

In a similar vein - "An adult patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his death" [4],[5]

Whilst such a situation is unlikely to be faced by a dentist in general practice the principle remains paramount. A patient can refuse treatment offered, even if it is in the patient's best interests.

The Human Rights Act 1998 also creates obligations for clinicians and Article 8, (the right to respect for privacy, family life and correspondence) and Article 10 (the right to freedom of expression including the right to receive and impart information) are likely to be engaged in the issue of consent.

It is a "fundamental principle, now long established, that every person's body is inviolate" [6] A patient's freedom to consent and make a decision about their own body is constrained by the choices given by the dentist in clinical practice , that are available and suitable for their needs and the patient cannot demand whatever treatment they wish. Furthermore a patient cannot compel a dentist to provide treatment that is judged by that clinician not to be in the patient's best interests.

Consent is essentially an internal state of mind for the patient and as a process it might not be complete even where a patient has signed a consent form as they may still be harbouring doubts about what they have agreed to undergo. From a legal perspective a signed and completed consent form is not an essential element of consent, apart from treatment under sedation and general anaesthesia, but it may be evidence of a valid consent or at least some protection for the dentist that a process was established in order to secure the relevant agreement to have the treatment done.

THE FUNCTIONS OF CONSENT ARE

a) Legal- it converts unlawful touching (battery) into lawful practice

b) Ethical-it respects a patient right to self determination

c) Clinical-it makes it easier to treat patients with better outcomes

LEGAL

BATTERY

Failure to obtain consent before touching someone constitutes the crime of battery and the tort of trespass for which damages may be awarded in civil law and for which in extreme cases constitutes the criminal offence of assault. This was summarised in a House of Lords decision thus "Prima facie, therefore, in the absence of consent all, or almost all , medical treatment and all surgical treatment of an adult is unlawful, however beneficial such treatment might be. This is incontestable" [7]

In reality, the courts are very reluctant to frame actions against health care professionals in term of trespass and battery since battery is an intentional action. There are notable exceptions to this. Ian Paterson, a breast surgeon who intentionally wounded his patients, was jailed for 20 years for treatment that was described as unnecessary, "brutal and sustained" over a 14 year period[8]. Most claims for injury in a clinical context involve allegations of negligence or carelessness and dentists are most often acting in good faith.

The threshold to avoid a claim for battery is quite low in that all that is required is to provide information in broad terms as opposed to the detail which would be required to obtain consent as part of a dentist's duty of care.

This approach was firmly established by Bristow J in *Chatterton v Gerson*[9] "In my judgement once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of action on which to base a claim for failure to go into risks and implications is negligence, not trespass".

For example where a dentist has recommended the removal of a tooth for an abscess, in order for the patient's consent to be valid, from the point of view of battery, the dentist would need to inform the patient that a local anaesthetic would be required, the tooth would be removed and that it would heal up.

From the point of view of battery, it would not be necessary to give any information about the risks, benefits or alternative treatment though this would be essential to avoid a claim of negligence.

Nevertheless, in the only reported dental case in England, a dentist was found guilty of battery by reason of lack of consent to the treatment on those teeth that required no treatment [10] In this case it was proved that the dentist deliberately withheld information that the treatment was unnecessary because he knew that they would not have consented had they known the true position and the patients were awarded aggravated damages.

Justice Dyson noted "Typically the plaintiff went for a normal routine check-up, and was subjected to the course of treatment without any explanation at all…I am quite satisfied that the failure to inform in these eight cases was not mere negligence and that Mr Garett withheld information deliberately and in bad faith". Long and expensive courses of treatment involving fillings, root fillings and crowns were carried out often on virgin teeth in young patients. Thus if information is withheld in bad faith, the consent will be vitiated by fraud.

Judge Dyson noted "the plaintiffs would not have consented had they known the true position".

It is worth noting that many claims have been settled with this language being the pivotal factor – had the patient been made fully aware, they would never have embarked on treatment. Lawyers will often cite "lack of valid consent" as part of the allegations listed though it will depend on the specific circumstances whether that is a legitimate basis upon which to base a claim.

NATURE OF CONSENT

Consent to treatment may be implied or expressed.

IMPLIED CONSENT

Many patients do not explicitly give express consent but their agreement may be implied by compliant actions[11]. A patient who attends your surgery for a check-up or in pain implies their consent to an examination of their mouth by sitting in the chair and opening their mouth. They have consented to nothing else and in order to carry out any invasive procedure such as periodontal probing, percussion or vitality tests or a radiographic examination, express consent is required

EXPRESS CONSENT

Express consent is given when patients confirm their agreement to a procedure or treatment in clear and explicit terms, whether orally or in writing. There is no requirement in English law that consent should be in writing but it is considered good practice in certain procedures such as surgical extractions of impacted wisdom teeth, implant placements or elective treatment. The GDC require written consent where treatment involves conscious sedation or general anaesthesia[12].

Written consent however on its own, without an explanation, is insufficient and certainly the usual catch-all clause relating to “any additional procedures deemed necessary “ will only be valid in certain narrow circumstances.

There are three essential components to valid consent

a) competence

b) voluntariness

c) information and knowledge

A) **Competence** means that the patient has sufficient ability to understand the nature of the treatment and the consequences of receiving or declining that treatment. The legal term is capacity.

B) **Voluntariness** means that the patient has fully agreed to have the treatment and there is no coercion or undue influence to accept or decline the treatment.

C) **Knowledge** means that sufficient comprehensible information is disclosed to the patient regarding the nature and consequences of the proposed and alternative treatments.

All these three elements are interdependent but must be present for consent to be ethically and legally valid.

Consent is not a single event but a process and a good working definition from the Department of Health in the UK of it is as follows:

> The voluntary continuing permission of the patient to receive particular treatments. It must be based upon the patient's adequate knowledge of the purpose, nature, likely effects and risks of that treatment including the likelihood of its success and a discussion of any alternative to it, including no treatment.

The emphasis on "continuing permission" is important. Take for example a patient requiring molar root canal therapy. If during the procedure, a difficulty is encountered such as a curved or sclerosed canal, further consent from the patient is required if the success of the therapy may be compromised and the prevailing situation is different from when treatment commenced. This preserves the autonomy of the patient.

This further consent procedure provides the patient with an opportunity to weigh up the risk of continuing or leaving the canal unfilled against a decision to extract the tooth. Communication and consent go hand in hand so that the patient is provided with sufficient information to give continued permission for that particular treatment. Once given however, a patient may withdraw consent at any time, including during the performance of a procedure.

CAPACITY

Before a patient can give a valid consent to dental treatment they must be deemed in law to possess the required capacity. They must be deemed to be "competent". If they lack capacity or are considered "incompetent" they can be treated without their consent though other important safeguards exist.

The approach to capacity both ethically and legally is a "functional" one driven by the process of how the patient comes to a decision. It can also be described as a cognitive test.

The Mental Capacity Act 2005 provides the legal framework for testing legal capacity in England and arose out a number of legal cases including *Re C*

Legal case for test of adult capacity Re C

Re C (adult :refusal of medical treatment) [1994] 1 All ER 819

C, aged 68 and of Jamaican origin was, following the stabbing of his ex partner, sentenced at the Old Bailey to 7 years imprisonment in 1962. Whilst serving the sentence he was diagnosed as suffering from chronic paranoid schizophrenia and was transferred to Broadmoor. There he stayed and mellowed with age. In 1993 an ulcerated foot was diagnosed to be gangrenous and a consultant vascular surgeon at nearby Heatherwood Hospital advised amputation below the right knee without which he only had a 15% chance of living. C refused to give his consent to the amputation preferring to die, if necessary , with both legs rather than one. He consented to more conservative treatment under general anaesthetic but there still remained a risk of death. The Hospital therefore applied to the court to have his leg amputated in the eventuality it was required, without the patient's consent on the basis that he lacked the capacity to understand the implications. C meanwhile trusted in his own decision believing he was right, that god was on his side and that in his delusional state, his belief that his international career in medicine in which he never lost a patient would stand him in good stead.

In his judgement, the Justice Thorpe granted the injunction to C preventing the hospital from now or in the future amputating C's leg without his consent and did so accepting that C had capacity on the three stage test described

1) comprehend and retain the relevant information

2) believe it

3) weigh it in the balance so as to arrive at a choice

Justice Thorpe summed it up thus:

"Although his general capacity is impaired by schizophrenia, it has not been established that he does not sufficiently understand the nature, purpose and effects of the treatment he refuses. Indeed, I am satisfied that he has understood and retained the relevant information, that in his own way he believes it, and that in the same fashion he has arrived at a clear choice"

Ironically, the patient made a full recovery without the need for surgery so maybe he wasn't as delusional as the doctors thought!

The test of capacity is that the person concerned should have the ability to understand the nature and purpose of the proposed care and there is a presumption that adults over 18 years old have a capacity to consent.

(see section below on **Children and consent**)

ASSESSING CAPACITY

Every person is presumed to have the capacity to consent to or refuse medical treatment unless and until that presumption is rebutted[13]. It is for the medical professional to demonstrate the patient lacks capacity.[14] Because an adult who is deemed to have capacity can make any decision they wish in terms of how they should be treated no matter how bizarre and irrational or how little that decision would be in their own best interest, the test for capacity is an important one.

Essentially then, if a patient is judged to be competent, their consent or refusal of dental treatment is decisive. If a patient is incompetent, they may be treated without their consent.

Whilst the vast majority of adult patients attending the average general dental practice for treatment would be deemed to have capacity, there are other important considerations.

With an ageing population, dental practices will increasingly encounter patients who have cognitive impairment and whilst it is not an exclusively older person's disease, many people live with dementia. General dental practitioners, who see their patients regularly over a long period of time, are well positioned to identify changes in their patients[15].

Dementia is an umbrella term. It describes the symptoms that occur when the brain is affected by certain diseases or conditions that include memory loss, mood change and problems with reasoning, attention, concentration, communication and geographic orientation

There are many different types of dementia although some are far more common than others such as Alzheimer's disease and fronto-temporal dementia[16].

In addition to an aging population, practices will be seeing more medically complex patients on polypharmacy as well as socially isolated patients attending on their own, without family or carers.

Since treating a patient without their consent is a significant step to take, a dentist has a duty to assess and prove that he has a "reasonable belief" that the individual lacks capacity to make a particular decision at a particular time.

Reasonable belief must be based on objective reasons and the decision maker must have taken reasonable steps to establish capacity is lacking[17].

It is important in this respect to recognise that a person may have capacity to make some decisions but not others, depending on the complexity and the significance of the decision. For example, the patient may be able to choose the time of their appointments, the shade of their dentures or crown but may lack the capacity when making decisions about which teeth to extract or more involved treatment planning issues. This is why assessing capacity is "decision specific"

Capacity can fluctuate over time and can be partially or temporarily lost. In essence therefore there are no clear boundaries between capacity and incapacity and there are therefore degrees of capacity.

Whilst some people may always lack capacity by virtue of a certain condition or severe learning difficulty that has affected them since birth , other people may later acquire the necessary skills to have the capacity for personal decision making.

There are five key principles in the Mental Capacity Act 2005 which underpins any decisions made under the Act and set out in Section 1 of the Act

- A person must be assumed to have capacity unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision or to lack capacity merely because he makes an unwise decision.
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

How is capacity assessed?

This is a two stage process.

The first question is a diagnostic threshold test and asks:

<u>Does the person have an impairment of, or a disturbance in the functioning of, their mind or brain?</u>

Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

• conditions associated with some forms of mental illness

• dementia

• significant learning disabilities

• the long-term effects of brain damage

• physical or medical conditions that cause confusion, drowsiness or loss of consciousness

• delirium

• concussion following a head injury, and

• the symptoms of alcohol or drug use.[18]

If the answer to this first question is yes then the stage two functional part of the test asks:

<u>Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?</u>

A person is considered *unable* to make a decision if they cannot

1.understand information about the decision to be made (the Act calls this 'relevant information')

2. retain that information

3. use or weigh that information as part of the decision-making process, or

4. communicate their decision (by talking, using sign language or any other means)

So this means that whilst the patients may have dementia or exhibited symptoms of alcohol or drug use, they may still pass the second stage of this test and therefore be judged to have capacity.

For the purposes of the Act, "relevant information" must include what the likely consequences of a decision would be; the possible effects of deciding one way or another, and also the potential consequences of making no decision at all.

A patient only has to retain the information in their mind long enough to make an effective decision. Just because a person can only retain information for a short while does not mean they lack the capacity to decide – it depends on what is necessary for the decision in question. Notebooks and voice recorders can assist patient's record and retain information.

The basis upon which the decision is made to deem the patient lacks capacity needs to be recorded in the notes. Is it because they could not understand, recall ,make a decision or communicate or a combination of the criteria?

The requirements on a patient's understanding vary considerably with the complexity of the decision in hand. Thus some decisions in clinical dentistry may require a low level of competence such as the decision whether or not to carry out a filling when there is a hole in a tooth, visible clinically and obvious to the patient. Other decisions will demand a much higher level of understanding or "processing" of the information and therefore may be more difficult for a younger patient or mentally disabled adult.

Nobody has the power to consent to treatment on behalf of an incompetent adult. It is a commonly held belief that consent can be obtained from a spouse or parent or near relative. This is not the case. Whilst is might be useful to seek to involve members of the family or carers in deciding the best treatment for the patient their consent or failure to provide it is not binding on the dentist.

Best interests

In English law, the lawfulness of invasive treatment given to incompetent adults is determined by reference to what is provided in their best interests though "best interest" is deliberately not defined in law. A dentist has a duty of care to judge what is in the patient's best interest and is legally accountable for this decision.

The answer to the question "what is the patient's best interest" is not altogether clear and depends on the situation.

It is possible for two individuals conscientiously to apply the "checklist" in Section 4 of the MCA and come to different views as to where the patient's best interests lie; so long as both views were reasonable , both could act upon their beliefs to carry out routine acts of care and treatment, safe in the knowledge that they were protected from liability under Section 5 MCA 2005 [19]

Firstly however, the test of best interest is an objective one and therefore the subjective assessment-what would the patient want if they were competent to decide for themselves-does not feature.

Secondly, best interests where invasive treatment is provided, should also incorporate best medical interest as well as emotional and welfare issues. The decision to subject a patient to a general anaesthetic for example for multiple restorations and extraction needs to take into consideration whether there is any pain, whether extensive treatment will obviate further treatment, whether the patient is capable of functioning with fewer teeth in this example and whether such treatment will improve their overall health. The treatment decision must also be based around the least restrictive option and where local anaesthetic can be used safely and effectively instead of a general anaesthetic that would be the choice that fulfils one of the MCA's key principles.

Best interest should take into account personal factors such as the patient's psychological health, well being, amenity and quality of life[20]

It is critically important to understand that the purpose of the process is to arrive at the decision that health and social professionals reasonably believe is the right decision for the person themselves as an individual human being[21] –not the decision that best fits with the outcome that the professional or a third party desires. In a dental situation, a clearance for an adult with a compromised dentition may make it easier for a carer to supervise oral health where a denture is provided, but this also has to be in the patient's best interest.

A best interest meeting (BIM) can be conducted where the patient has family members or carers involved and the patient is deemed to lack capacity. The parties can make a contribution to the decision around the treatment plan and then a form can be used to document this.

Where patients have no next of kin, parents or children and are "un-befriended", an Independent Mental Capacity Advocate (ICMA) should be appointed where there is no urgent dental care required. Routine extraction of tooth under local anaesthetic is not deemed a serious medical treatment however and consequently the step of appointing an ICMA is unlikely to be necessary in primary dental care[22].

The concept of best interest is thrown sharply into focus when a parent wants treatment for their child which clinicians believe is not in their best interest. These can be very emotive cases where a hospital is proposing withdrawing treatment, discontinuance of which will lead to the child death. The courts have jurisdiction in these matters but the court has no power to require doctors to carry out a medical procedure against their own professional judgement. In these cases the parents have often lost trust in their treating doctors and look to the court for support[23]. The burden of the decision about whether treatment should be continued falls to the court.

" But the role of the court is to exercise an independent and objective judgment. If that judgment is in accord with that of the devoted and responsible parent, well and good. If it is not, then it is the duty of the court, after giving due weight to the view of the devoted and responsible parent, to give effect to its own judgment. That

is what it is there for"[24].

VOLUNTARINESS

The second element of consent is that it should be voluntary and freely given without coercion.

A consent obtained by misrepresentation or fraud is legally viewed as no consent at all whilst from an ethical point of view there can be no moral authorisation for treatment since it violates the patient's dignity and right to self-determination.

This coercion may be subtle, ranging from issues of quality, price and value and be influenced by the practice environment, the dentist's personality or other team members. The coercion may of course be exercised with benevolent intentions where the practitioner and patient differ in their assessments of how the patient's welfare is best served [25]and in this case it would be difficult to argue that consent has been vitiated.

The test case in English law in which the issue of patient's consent was said to be unduly influenced by someone else was Re T.

RE T (ADULT REFUSAL OF TREATMENT)

[1992] 4 ALL ER 640 (1992) 9BMLR 46 (CA)

IN 1992 MISS T, AN ADULT AND THEN 34 WEEK PREGNANT WAS INVOLVED IN ROAD TRAFFIC ACCIDENT. SHE WAS ADMITTED TO HOSPITAL SOME DAYS LATER WITH CHEST PAINS WHICH WERE DIAGNOSED AS PLEURISY OR PNEUMONIA. ALTHOUGH BROUGHT UP BY HER MOTHER, A FERVENT JEHOVAH 'S WITNESS, MISS T WAS NOT A MEMBER OF THAT FAITH AND HER PATERNAL FAMILY, WITH WHOM SHE WAS LIVING WAS OPPOSED TO THE SECT.

THE FOLLOWING DAY AFTER A VISIT FROM HER MOTHER, WHILST IN CONSIDERABLE PAIN, COUGHING SPUTUM AND IN THE EARLY STAGES OF LABOUR SHE SAID SHE DID NOT WANT A BLOOD TRANSFUSION IF IT BECAME NECESSARY. SHE SIGNED A FORM TO THIS EFFECT BUT IT WAS NOT EXPLAINED TO HER THAT IT MIGHT BE NECESSARY TO GIVE HER A BLOOD TRANSFUSION TO PREVENT INJURY TO HER HEALTH OR EVEN TO SAVE HER LIFE. THE BABY WAS DELIVERED BY CAESAREAN SECTION BUT WAS STILLBORN AND THAT NIGHT MISS T'S CONDITION DETERIORATED FOLLOWING AN ABSCESS IN HER LUNGS. HER CONDITION ON INTENSIVE CARE WAS CRITICAL AND A TRANSFUSION WAS GIVEN.

THE COURT OF APPEAL JUDGES AGREED THAT IT WAS LAWFUL TO GIVE THE BLOOD TRANSFUSION BECAUSE MISS T WAS UNDULY INFLUENCED BY HER MOTHER AND WOULD NOT HAVE REFUSED THE TRANSFUSION HAD HER MOTHER NOT BEEN THERE.

Whilst this case deals with the refusal of consent, more commonly in practice the situation arises when a patient has apparently agreed but may claim that the consent was not freely given. Thus "undue influence" on the patients who may agree to a course of treatment may vitiate any consent that was given.

"It is wholly acceptable that the patient should have been persuaded by others of the merits of a decision and have decided accordingly. It matters not how strong the persuasion was, so long as it did not overbear the independence of the patient's decision" (Lord Donaldson MR (Re T)

It is important to give the patient time to think over and digest the information provided to them, or at the very least give them the opportunity to go home and discuss proposed treatment and costs with others or obtain a second opinion if needed.

Dentists can be open to criticism if complex treatment is started on the same visit as the examination. Patients may feel coerced into treatment when not given sufficient time to reflect on what they have been told.

Coercion may be covert. If the dentist does not offer the full range of choices, possibly because they have preconceived ideas about the patient wants or because they do not want to provide a particular treatment, this is denying the patient the right to exercise their autonomy and make a free choice.

For consent to be valid the patient must have, not only sufficient information but also have made a voluntary choice, free from any influence from the operator or indeed a third party like a family member as in Re T.

Lord Donaldson in *Re T* pointed to two main considerations when examining influences. The first is the strength of will of the patient. If the patient is in pain, depressed or tired or being treated with drugs, he or she is less likely to resist the influence of others. This will include the dentist offering options that they may accept because they are in pain and simply want a quick solution, one which they might not ordinarily have chosen.

The second is the patient's relationship with the persuading party. A close family relationship heightens concern, especially in cases where religious beliefs are the reason for refusing treatment. The stronger the relationship, the greater is the ability of the persuader to override the decision-making process of the patient.[26]

The field of neurolinguistic programming (NLP) demonstrates that our ability to influence patients may be more subtle than overt and with perhaps sinister overtones of coercion. Simply put, the words we use to describe a particular procedure can make one option of treatment more desirable than another. Using emotive words like " cut the gum" "risk of fracturing the root" "painful and uncomfortable" may make an extraction less attractive than root canal treatment for example without necessarily intending to do so.

Withdrawal of consent

Continued treatment depends on continuing consent and a patient is entitled to withdraw their consent at any time during a procedure. In clinical practice this might happen because the patient is in severe pain, stressed or anxious and wants to abandon or delay the treatment. The patient's wishes should be respected and the patient advised if it is safe to delay treatment or whether further complications may arise following the failure to complete the treatment.

In *Connolly*[27] it was found that since the patient had analgesic drug and was sedated for the angiogram procedure she did not have the capacity to withdraw her consent to treatment during the procedure that she alleged led to dissection of the left descending artery. Furthermore the hospital was entitled to continue the treatment even without consent "if stopping at that point would genuinely put the life of the person at risk"[28]. That is unlikely to ever be the case in general dental practice.

KNOWLEDGE

The essential component of the knowledge element is how much information does a patient need to know about a particular dental procedure in order for the consent to be valid and therefore defensible in any negligence action brought by the patient.

An autonomous decision requires sufficient information to be provided but at their most vulnerable , when they are perhaps unwell "patient are called upon to digest increasing quantities of highly technical information and then to decide from among a myriad of treatment alternatives, while various "strangers at the bedside" remind the patients that it is "their decision"[29]

An important case that demonstrates how English law dealt with this aspect of consent is *Sidaway* .

At the time no previous case had come before the House of Lords on the issue and Lord Scarman asked "Has the patient a legal right to know, and is the doctor under a legal duty to disclose, the risks inherent in the treatment which the doctor recommends? If the law recognises the right and the obligation, is it a right to full disclosure or has the doctor discretion as to the nature and extent of his disclosure"

Sidaway (Sidaway v Board of Governors of the Bethlem Royal Hospital [1985] A.C 871).

Mrs Sidaway suffered from pain in her neck, right shoulder and arms and underwent an operation designed to relieve her symptoms. Prior to the operation, the surgeon explained to her that there was a 1-2% chance of damage to the spinal column and the nerve roots where they emerged from the spinal column. However, the risk of damage to the spinal cord itself was not mentioned prior to surgery. In the event unfortunately Mrs Sidaway's spinal column was damaged leaving her severely disabled after the operation. Her claim for negligence was based on her assertion that the surgeon

had failed to disclose or explain all the risks inherent in the operation. When eventually the case came before the House of Lords,Mrs Sidaway was unable to prove her case but the Court availed themselves of the opportunity to explain a doctor's duty under the circumstances. They rejected the concept of "informed consent" saying this was totally impractical and said it was a matter of clinical judgement whether a risk should be disclosed or not to the patient.

This was completely different from the United States of America where the law requires that the patient is given all the relevant information leading to sometimes bizarre consent forms in which every risk known is disclosed.

Subsequent to this judgement, based largely on the dissenting and prescient views expressed by Lord Scarman ,cases after *Sidaway* suggested that the English courts would increasingly be expecting clinicians to provide information required by the "prudent" patient.

In *Pearce v United Bristol Healthcare Trust* (1998) 48 BMLR 118 (CA) Lord Woolf MR concluded that "if there is a significant risk which would affect the judgement of a reasonable patient, then in the normal course it is the responsibility of a doctor to inform the patient of that significant risk, if the information is needed so that the patient can determine for himself or herself as to what course he or she should adopt". In this case the claimant who was expecting her sixth child was overdue by two weeks and requested her consultant to have an induced labour or caesarean section. The consultant advised her to let nature take its course but the child died *in utero* a week later and was stillborn.

The question was whether the consultant should have advised Mrs Pearce about the risk of stillbirth if she waited and whether that information would have altered her decision to have a natural birth. In this case, the risk of stillbirth was something like 0.1-0.2% and therefore could by no means be considered a significant risk. The Court of Appeal therefore agreed that since the risk was not significant there was no duty to disclose it.

It is clear however even in English law that the patient should be given sufficient information in order to make an informed choice.

So what information should be given to a patient contemplating treatment?

a) The patient must be informed of any serious risk, even if that is of low frequency

b) The patient should be warned about transient and less serious risks that occur more commonly.

The duty to disclose is, to some extent, dependent upon the risk: benefit ratio of treatment so, in aesthetic procedures, failure to disclose even remote risks may be difficult to justify but also now what a patient might regard as important.

Therapeutic privilege

The law allows, in certain circumstances for the clinician to withhold information from the patient in their best interests, that they would otherwise be expected to disclose. This was summarised by Chief Justice Laskin[30] ; "a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommend surgery or treatment and the doctor may, in such a case, be justified in withholding or generalising information as to which he would be otherwise required to be more specific".

These cases are likely to be "wholly exceptional"[36] and unlikely to feature at all in primary care dentistry as the reason not provide the patient with all the relevant information.

Furthermore, there are strong arguments in favour of informing patients, since even if they are ill or emotionally distraught they should not be robbed of their autonomy in an ill judged desire to protect them. Although the motivation behind economy with the truth is often well meant, a conspiracy of silence usually results in a heightened state of fear, anxiety and confusion--not one of calm and equanimity.[31]

Standards of disclosure

The legal standards of disclosure can be usefully divided into three; the professional test, the objective prudent patient test and the subjective particular patient test.

For some time, the United States, Australia, South Africa and Ireland have applied the *objective standard* and the *subjective standard*, both of which were different from the UK standard which was the *professional test* of whether a warning should be given.

This has certainly been the case until the judgement in the *Montgomery* case which has brought the UK into line with other jurisdictions as well as the ethical guidance provided by the General Dental Council.

In the objective standard, the question asked is what would a reasonable or "prudent" patient expects to be told about a procedure, in order to make a decision. The subjective standard is more patient focused and here it is a question of what would be important to a <u>particular</u> patient with regards to the risks of what treatment is being proposed at that <u>particular</u> time.

WHAT LEVEL OF RISK?

The landmark ruling that first established what information about risks should be conveyed to patients was the Bolam case. (see Chapter Five Clinical negligence)

Essentially the Court decided that it was up the doctor to decide what risks to convey to a patient about a particular procedure. As long as that accorded with a responsible body of professional opinion, that was an acceptable approach.

The idea that the profession should exclusively determine what information should be disclosed to patients was modified sometime later by the claim following the care provided to Patrick Bolitho, a two year old boy admitted to hospital for croup.

A number of experts gave different opinions about the failure to intubate Patrick, offering different arguments for and against. Whilst the court accepted the Bolam principle that medical experts should be relied upon in making clinical decisions, "the court should not accept a defence argument as being "reasonable", "respectable" or "responsible" without first assessing whether such opinion is susceptible to logical analysis".[32]

For many commentators this was the start of redressing the balance away from the bygone era of medical paternalism.

This raises the next pertinent question- what is the logical threshold above which a risk should be disclosed to a patient by the clinician to allow the patient to make an informed decision?

In the Sidaway case it was suggested by one of the lawlords that a 10% risk of a side effect is a "significant risk" and that it should be disclosed to the patient as part of the consent procedure.

That is the starting point but whether a risk is significant or not cannot be determined simply in terms of percentages but must be considered in relation to what a "reasonable patient" would consider relevant to their decision. This is the important point that was made in the Montgomery case.

Montgomery v Lanarkshire Health Board [2015] UKSC 11

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 and to the baby. Seventy percent of cases of shoulder dystocia can be dealt with by the 'McRoberts' manoeuvre during delivery , 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 vaginal 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.

There was difficulty in delivering the baby as a result of shoulder dystocia and during the 12 minutes it took to free Sam he was starved of oxygen as the umbilical cord became occluded. Sam 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.

What the Supreme Court said in Montgomery 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. What constitutes a material risk will vary from patient to patient and therefore consent needs to be patient specific

Equally important is the judge's ruling that the percentage risk of a situation occurring should not be the sole determinant of the disclosure of that risk to the patient.

The issue of risks was clarified in *Duce*[33] as atwo fold test

(1) What risks associated with an operation were or should have been known to the medical professional in question at the time. That is a matter falling within the expertise of medical professionals. Therefore if a the risk is not known then there is no requirement for a clinician to advise of that risk and therefore no need to consider the second limb of this test about materiality.

(2) Whether the patient should have been told about such risks by reference to whether they were material. That is a matter for the Court to determine . This issue is not therefore the subject of the Bolam test and not something that can be determined by reference to expert evidence alone

Post Montgomery, common law will no doubt continue to develop[34] and focus on a patient centred approach with judges expecting clinicians to apply this through the consent process through an on-going dialogue and relationship with patients . Simply signing a consent form which contains the standard risks of the proposed treatment or procedure is no longer enough.

Some dental examples of degree of risk

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.

There are also other risks related to operative dentistry such as the extrusion of hypochlorite[35] or instrument fracture[36] in root canal therapy and paraesthesia from an inferior dental block.[37]

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 patient of the benefits sought to be achieved by the treatment, the alternatives available and the risks involved in those alternatives. Thus simply quoting a percentage risk without putting it into the context of the patient's own views and clinical and social situation is insufficient.

Clinicians, using personal audit outcomes, may offer their own success rates to inform a patient to have a particular treatment. This might have the effect of persuading them to pursue the operation offered. However " a clinician who uses percentages may accurately describe his/her personal track record of success but this may be significantly higher than the average and, in the ex post facto world of litigation, experts might assess prospects of success by reference to the average and not the individual'[38].In this particular case of elective spinal surgery the judge concluded that had the patient been given the risks that would normally occur (ie a 50/50 chance of improving the back pain as opposed to nearer 80-90%) then the patient would have either declined the surgery or postponed it to think longer pending a second opinion. The problem or overstating the benefits and understating the risks especially in private elective surgery where there is also little time between the consultation and tretamnet for the patent to reflect , the consent process might be considered shaky[39].

Local anaesthesia

Should we routinely warn patients of needle breakage during a ID block?

The risk of this is very low[40] but the impact may be significant to the patient.

What about paraesthesia following an ID block?

In an interesting case from Western Australia[41], the claimant brought a claim against the dentist following paraesthesia after the administration of an ID block. The patient said he would never have had it done had he known of this risk. The risk of persistent lingual nerve paraesthesia was judged to be 1:12,000 but the claimant lost the case on the basis that the risk was small, the impact would be low and it is unlikely that he would have agreed to have the treatment without the local anaesthetic.

In consideration of the Montgomery judgment, if a particular patient had Bell's Palsy you may consider warning them that an ID block can trigger this. You may at this stage consider other forms of anaesthesia (eg buccal infiltrations) to reduce the risk.

It is important to document this conversation *" patient informed of higher risk of complications post IDB eg Bells Palsy , especially in light of patients MH."*

Endocarditis

Guidance around the prescribing of antibiotics prophylactically for patients undergoing invasive dental treatment who might be at increased risk of bacterial endocarditis varies across the world and is controversial[42] . Applying the Montgomery judgment to these at risk patients would require a risk assessment to be taken for the specific patient to establish whether for this particular patient, following advice from the patient's cardiologist, they may require prophylactic antibiotics which otherwise would not be applicable for other similar patients with the same condition**.**

This requirement to understand the personal significance of particular risks for your patient would appear to create a significant burden on the clinician necessitating extensive dialogue between the patient and clinician whenever treatment is planned.

Whilst the dentist themselves may not regard a particular risk to be likely or particularly grave if it did occur, the patient may attach a different significance to the risk , however insignificant in impact.

The GDC Standards guidance reflects this position

3.1.3 You should find out what your patients want to know as well as what you think they need to know. Things that patients might want to know include:

• options for treatment, the risks and the potential benefits;

• why you think a particular treatment is necessary and appropriate for them;

• the consequences, risks and benefits of the treatment you propose;

• the likely prognosis;

• your recommended option;

• the cost of the proposed treatment;

• what might happen if the proposed treatment is not carried out; and

• whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply

The decision in 1992 in Australia in Roger v Whitaker[43] established the concept of the particular patient and, since they are ultimately carrying the burden of that risk, the patient should be entitled to know enough about the risks and how it affects them to make that choice of whether to undergo the treatment or not.

Rogers v Whitaker (1992)

Mrs Whitaker, the claimant had been nearly blind in her right eye since she was nine years old. In 1983, at age 47, after a routine eye check-up she was referred for possible surgery. The ophthalmic surgeon Dr Christopher Rogers, advised her that he could operate on her right eye to remove scar tissue, to improve its appearance and possibly restore significant sight to that eye as well as assisting in the prevention of glaucoma.

Unfortunately, following the operation there was no improvement in her right eye and Maree Whitaker developed inflammation and sympathetic ophthalmia (1:14000 chance) in her healthy left eye, which led to complete loss of sight in this eye and thus almost total blindness.

Sympathetic ophthalmia (SO) is a bilateral diffuse granulomatous intraocular inflammation that occurs in most cases within days or months after either surgery or penetrating trauma to one eye. The injured eye is known as the exciting eye and the fellow eye, developing inflammation days to years later, as the sympathizing eye. The sympathizing eye demonstrates signs of the ocular inflammation without any apparent reason. Although rare, SO remains an important public health problem because it can cause bilateral blindness[44]

There was a recognised risk of 1;14000 of sympathetic ophthalmia occurring but the patients was not warned of this risk.

The Australian courts rejected Bolam saying "…particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded, and, instead, the courts have adopted… the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration that a person is entitled to make decisions about his own life'

With regards to the need for a warning the judges concluded

"But it could be argued, within the terms of the relevant principle as we have stated it, that the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective".

Whilst initially there were many successful claims against healthcare practitioners following on from this judgment in Australia, the pendulum has begun to swing against patients in that jurisdiction in 'failure to warn' cases on the grounds of causation.[45]

Hindsight is a wonderful thing

In other words, even if the patient had been warned of the risk, would they have still gone ahead with the treatment since the usual defence is that had they been advised of the risk, they would not have undergone the procedure?

The courts recognise this "prism of hindsight"[46] in *Rosenberg v Percival* , a sagittal split osteotomy case that resulted in TMJ problems, and they determined that the reliability of the evidence provided by the patient in making their claim needs to be assessed in the context of the patients prevailing condition, knowledge and alternative options.

In *Rosenberg v Percival* the patient's contention she would not have proceeded with the treatment had she known of the very slight risk of TMJ problems was put into context by the trial judge:

- the 20 years' experience that the patient had had as a qualified nurse with a doctorate of philosophy in nursing and a senior lectureship in nursing at a university;
- the patient knowing that surgical operations carry inherent risks of harm;
- the patient suffering from a worsening condition of malocclusion for a number of years;
- the consulting of several specialists for the purpose of remedying the condition and getting the best result;

- the osteotomy procedure being the operation most likely to produce the best result in her case;
- the osteotomy being a common operation;
- the risk of suffering the harm that the patient suffered being very small; and
- the patient subsequently undergoing another operation to correct the consequences of the temporomandibular joint disorder.

Rosenberg v Percival was judged to be "a long awaited glimpse of daylight in Australia after a decade {since Rogers and Whittaker} in which the clinicians burden in respect of the duty to warn/inform had become increasingly onerous"[47]

In *Diamond v Royal Devon & Exeter NHS Foundation*[52] the judge found that whilst the claimant Lucy Diamond had not been warned that the risk of a particular repair procedure of her abdominal wall could create significant risks in pregnancy later on her view that she would have opted for the less risky but more unsuccegul single suture repair was coloured by hindsight.

'…recalling specific events or conversations is markedly different from attempting to reconstruct what her response would or might have been if given certain information. Expert witnesses, lawyers and others are trained not to use the benefit of hindsight to inform their opinion of what might or should have happened. It is, however, human nature for people to permit that which eventuated to influence their thinking on what they might have done if warned about a particular risk.'

The judge continued

'Unquestionably, in my view, this sad outcome [not being able to have another child] colours and informs her view of what she would have done if she had been appropriately warned'.

The judge here did not question the Claimant's integrity in giving evidence. In his view she genuinely believed and had convinced herself that with proper advice she would have made a different decision[48]. 'But it does not of course automatically follow that what she now believes to be the case would in fact have been the position at the material time'.

There is balance to be struck between providing information to enable the patient to come to a decision about the treatment they are undergoing and explaining in graphic detail the treatment or the attendant risks which may result in deterring the patient from undergoing the treatment that may well be in their best interests.

Without adequate information, patients have no realistic choice, and without good communication and consent, even the highest clinical standards ring hollow.

It is clear also that if a patient specifically asks about a risk of a particular treatment the dentist has a duty to answer truthfully and as fully as the patient requires.

Chester v Afshar

In *Chester*[49] the neurosurgeon Dr Afshar was found negligent for failing to warn his patient, Miss Chester of a small but unavoidable risk of 1-2% of the surgery leading to the seriously adverse result of cauda equina syndrome. Both sides agreed there was no negligence in the actual manner in which the surgery was carried out.

This case has also proved to be a significant, but controversial change in the doctrine of informed consent in English law.

The patient, Miss Chester did not state that, had she been given a proper warning as to the risks of cauda equina, she would never have had the operation. All she could have said was that she would have discussed matters with others and explored alternative options. In other words, the operation would not have proceeded on *that* Monday, but she might have agreed to have it performed at a later date, perhaps even by Mr Afshar himself. The risk on any such future occasion would have been the same i.e. 1-2 %.

Lord Hope expressed what has become known as the *Chester exception* thus:

Causation would be established if the following three stage test was satisfied

a) the injury was intimately connected with the duty to warn
b) the duty was owed by the doctor who performed the surgery to which the patient consented
c) the injury was the product of the very risk that the patient should have bene warned about when they gave their consented

This is to be regarded as a modest departure from established principles of causation.

This decision has potentially serious implications for clinicians. Failure to take adequate consent-and recording it-now overrides any argument that such failure did not cause the adverse outcome,

provided that the warning ought to have been given and the condition or consequence which ought to have been mentioned actually develops[50].

The case reaffirms the fundamental principle of patient choice and the absolute right of a patient to decide whether they will accept or reject the proposed treatment.

It will no longer be sufficient to record "warned of risks" or the equivalent which may leave dentists vulnerable. As highlighted in the above case, a detailed account of the specific risks about which a patient is warned ought to replace common shorthand notes. Using a read-do or do-confirm checklist is of particular use in these circumstances.

What if something goes wrong that is considered negligent. Does that negate the consent that has been given. In a case concerning the treatment of a painful recurrent neuroma in the patents foot it was found that even though there was a negligent omission of one stage of a three stage process, it did not negate the consent that was obtained nor make it a different operation for the purposes of consent.[51]

Because Chester departed from the established principles of causation it created great uncertainty about how consent cases were to be determined.

Duce[33] attempted to narrow the impact of Chester. This Appeal Court case revolved around the claimant Ms Gail Duce who had undergone a total abdominal hysterectomy (TAH) and bilateral salpingo-oophorectomy after suffering from heavy and painful periods. After surgery in 2008 carried out non negligently, she suffered serious and permanent neuropathic post op pain and alleged that the defendant surgeon had failed to warn her of the risk of developing chronic post surgical pain (CPSP) .

It was agreed by experts on both sides that the knowledge of neuropathic pain and its incidence was not well known or understood and hence there was no expectations on this warning being given. Therefore in terms of Montgomery consent it fails to meet the test of knowledge of the risks in the first place.

The *Duce* case also confirmed that the claimant still needed to demonstrate legal causation as well as the but for **factual** causation (see Chapter Five).In other words that the claimant still had to show that a different course of action would have taken by the patient if they had bene given appropriate warnings

Commentators now believe that Chester v Afashar is a remarkably narrow decision with little application to further cases

After care

Who looks after the patient after treatment? In *Gallardo* [52]the patient underwent an operation to remove a malignant gastrointestinal tumour. His case was that he was not made aware that it was malignant, believing it to be an operation for a gastric ulcer, nor that he needed regular scans and reviews. The tumour did recur 10 years later and follow up care was provided. He alleged that the hospital was negligent in not providing the information post operatively that it was a GIST (gastrointestinal stromal; tumour) which he was entitled to know. The hospital said that since he had ben transferred to private surgeon after the operation it was their responsibly to advise of the post op management. This case follows on from the Montgomery judgment in expecting clinicians to ensure patients provide advice about future treatment and aloo information and investigation which have already been done. It looks also at the tricky situation of management of patients between clinicians and this may occur in the management of patients who have had specialist care and returned to the GDP. Implants and orthodontics are obvious examples.

Specific risks and their impacts

Checklists seem able to defend anyone, even the experienced, against failure in many more tasks than we realised. They provide a cognitive net. They catch mental flaws inherent in all of us-flaws of memory and attention and thoroughness[53].

Informed consent requires the imparting of information that the patient would expect to know before agreeing to undergo a procedure. Permanent impairment of everyday activities, such as speaking , eating, kissing and smiling would certainly fall into this category. Leaflets specific to certain procedure are a useful way of outlining its major and significant risks, if it is documented in the notes that the relevant information was given and discussed in this form.

A patient must be made aware of the risks inherent in a particular procedure and of the alternatives even if that alternative may be less likely to be successful but not carry the same risks[54]

It is important also to recognise that the complications of a procedure that are specific to a patient's treatment such as their occupation may also have a significant effect on the patient's willingness to undergo a particular procedure.

For example, a patient who plays a wind instrument professionally may suffer more impact on their income and lifestyle if the removal of an impacted third molar resulted in permanent lingual paraesthesia than another patient.

The *Montgomery* case would require the dentist to emphasise this particular risk to the patient and the significance it would have on their ability to play the instrument were the risk to materialise.

It is argued that *Montgomery* entitles the claimant to make an informed decision in relation to those risks which the dentist, when judged according to a reasonable standard, considered to objectively material. This means that where there is range of opinion on the acceptable treatment an their risks , it is incumbent on the clinician to be aware of that range and to discuss it with the patient. In this way it is different from Bolam in that the dentist should give the objective material risks to the patient and not escape providing this information just because another body of dentist fail to do so.

Information about the level of risk in any particular aspect of clinical dentistry comes from peer reviewed journals. These may or may not be related to a particular type of practice or population and therefore to overcome this dentist ought to consider carrying out their own clinical audit on various aspects of dental care to establish their own data set to share with patients to enable them to make their decisions.

In the coming years there will doubtless be many more cases that revolve around the issue of the significance of a risk that a clinician should disclose to a patient and whether that risk would be material enough to influence the patient's decision about what treatment or test to undergo.

The earliest example of this post Montgomery is Mrs A v East Kent Hospital[55] which started five days after the Montgomery judgement was handed down. The case revolved around the disclosure of a chromosomal abnormality to a mother later in her pregnancy and whether, if she knew about it she would have elected to have amniocentesis and then a termination if the amniocentesis confirmed the abnormality. From the expert evidence put to him, the judge considered the risk of 1 in 1000 was theoretical, negligible or background and that the doctors had not obligation to disclose or discus this with the mother.

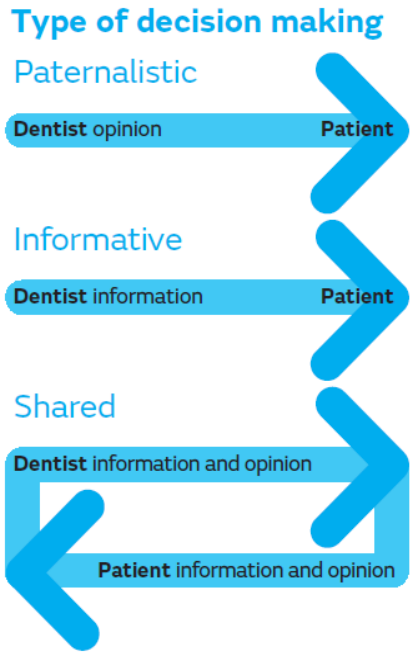
An interesting development is the recognition that if patients are no longer passive recipients of care who are able to readily access detailed and reliable information about their condition and the treatments available, they should accept some social responsibility for this. This evolving clinician-patient relationship was considered in Spencer v Hillingdon , the first opportunity of the lower courts to apply the decision of the Supreme court in Montgomery

"The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based on medical paternalism. They also point away from a model based on a view of the patient as being entirely dependent on information provided by the doctor. What they point towards is an approach to the law which, instead of treating patients as

placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults who are capable of understanding that medical treatment is uncertain of success and may involve risks, accepting responsibility for the taking of risks affecting their own lives, and living with the consequences of their choices.'[56]

Shared decision making (SDM)

With the increasing complexity and number of different choices available to patients for treatments set against the context of the cost of treatment, culture , values, rising expectations, patient autonomy and legal precedents it is perhaps not surprising that a model of decision making that takes into account all these issues has emerged[57]



Quite simply, shared decision making means finding out what is important to the patient. Shared decision making is the conversation that happens between a patient and their health professional to reach a healthcare choice together. This conversation needs patients and professionals to understand what is important to the other person when choosing a treatment.[58]

Shared decision making fulfills the moral and regulatory imperative of involving patients in their care but there is also compelling evidence that patients who are active participants in managing their health and health care have better outcomes than patient who are passive recipients of care.[59]

There is no doubt that this process is time consuming. Although clinicians are aware that they need to form partnerships with patients to support them in making decisions about their care, the time and workload pressures facing clinical teams pose significant challenges in providing the right level of support to patients throughout the consent process.[60]

In medicine, a number of Decision aids have been developed which are also available to assist patients and the NHS Shared Decision Making app is available on smart devices running Apple iOS or Android. They cover conditions such as diabetes, lung cancer, stable angina, sore throat and high cholesterol amongst others.

"I told him it would fail" is a common response when a patient complains about a particular treatment and the dentist is asked to justify their decision. This might occur when a patient is keen not to lose teeth and wishes to undertake treatment to prolong them against the clinician's better judgement. They may also decline to have treatment that is offered in their best interest to manage active disease or provide interceptive treatment to prevent future problems such as the provision of a cuspal coverage restoration on a heavily filled root treated tooth.

In shared decision making, these issues can be explored and responsibility jointly taken. It is important to record the conversations accurately in the records and to use language that reinforces the temporary nature of the treatment, for instance "*patient is aware of the temporary nature of the filling and that the tooth needs an extraction in the long term."*

Dentists are concerned that if this patient complains, they would be unduly criticised for agreeing with the patient's wishes or demands. Good record keeping and communication with the patient is the key to averting this.

Understanding the information

Delivering the information to the patient is one thing, whether or not they understand or remember it is another matter altogether.

40-80% of medical information provided by healthcare practitioners is forgotten immediately[61]. The greater the amount of information presented, the lower the proportion correctly recalled; furthermore, almost half of the information that is remembered is incorrect

Or they cannot recall it all even when it has been clearly given to them. Only 36.8% of orthodontic patients undergoing treatment could recall being told about decay and less than 21% could recall being informed about the risks of root resorption[62].

The technical terms, jargon and descriptions that clinicians might take for granted may well be alien to patients. There will always be an asymmetric relationship between the patient and clinician who is the expert with the knowledge. The purpose of consent is not to teach the patient about dentistry but is a communication process that aims to provide an enlightened understanding of the treatment.

"The doctor's duty is not therefore fulfilled by bombarding her patient with technical information which she cannot reasonably be expected to grasp, let alone by routinely demanding her signature on a consent form"[63]

The mere provision of information via a checklist approach for example does not guarantee understanding. The fundamental flaw is that the provision of information will not, in itself, guarantee that an autonomous decision is made. It only guarantees that the information has been passed from the clinician and fulfils the legal test but not necessarily the ethical one.

When providing information , a reasonable effort should be made to communicate the information to the patient recognising that the clinician may not know the patient particularly well as pointed by Morland J in *Smith.*[64]

"When recommending a particular type of surgery or treatment, the doctor, when warning of the risk, must take reasonable care to ensure that his explanation of the risk is intelligible to his particular patient. The doctor should use language, simple but not misleading, which the doctor perceives from what knowledge and acquaintanceship that he may have of the patient (which may be slight), will be understood by the patient so that the patient can make an informed decision as to whether or not to consent to the recommended surgery or treatment"

A clinician is expected to take reasonable steps to ensure that that the patient understands the information but this does to extend to testing that understanding.

A claim was brought by Mrs Al Hamwi against her GP as well as the consultant obstetrician at the Trust following the birth of her child with a genetic disability similar to other family members[65].

The case against the Trust obstetrician was that Mrs Al Hamwi had wanted an amniocentesis test but following a consultation with Mrs Kerslake, the obstetrician, she changed her mind.

She argued that this happened because

(1) she was given inaccurate or inadequate information about the risks of the amniocentesis test, or

(2) the information was given in an unbalanced way, or

(3) it should have been apparent that she had misunderstood the risks and Miss Kerslake should have corrected the misunderstanding

The judge found against Mrs Al Hamwi, approving of the information leaflet given to the patient about amniocentesis and the checklist of warnings contemporaneously recorded by the obstetrician in the notes. On the issue of whether there was an obligation that the clinician should have corrected her misunderstanding of the risks involved in the procedure the judge said:

"A patient may say she understands although she has not in fact done so … It is common experience that misunderstandings arise despite reasonable steps to avoid them. Clinicians should take reasonable and appropriate steps to satisfy themselves that the patient has understood the information which has been provided; but the obligation does not extend to ensuring that the patient has understood"

Where there are language difficulties sit is still incumbent on the clinicians and team members to ensure that every effort is made to communicate relevant information and advice an whilst it may be a difficult task in some case using appropriate service such as Language line should be utilised . A new born child suffered serous avoidable harm because of a failure on communication between the mother an the midwives.[66]

Conscious sedation

In general dental practice a combination of behavioural management techniques and reassurance is normally enough to manage patients with anxiety and sufficient to allow local anaesthesia to be utilised. It is the responsibility of the dentist to make a thorough assessment of the patient before deciding if conscious sedation is indicated.

The use of conscious sedation may be indicated for special care patients, certain medical indications or difficult clinical situations.[67]

Consent obtained on the day of treatment is not appropriate except when immediate treatment is in the best interests of the patient. Consent obtained prior to the day of treatment must also be re-confirmed on the actual day of treatment[68].

Patients who are already sedated cannot be regarded as competent to make valid decisions regarding consent for treatment and therefore it is important that if treatment may change during the procedure, the patient is advised of this possibility and their views sought in advance.

REFERRAL FOR GENERAL ANAESTHESIA

31st December 2001 was the final day on which a general anaesthetic could be given in a dental practice in the UK. Henceforth all dental treatment requiring a general anaesthetic would have to take in a hospital setting which had immediate access to critical care facilities[69] .

In November 1998 the GDC introduced guidelines for dental practitioners when referring patients for general anaesthesia(GA). The referring practitioner has to consider other means of pain and anxiety control and behavioural management. If these are not viable or successful, only then should GA be considered an option. The referring practitioners also have the responsibility of discussing the risk involved with GA and alternative methods of pain and anxiety control with the patient, parent or guardian. The letter of referral should also contain a clear justification for providing GA.

Whilst this is good practice, the legal doctrine of consent places the need to get informed consent at the time of the procedure, the clear responsibility of the team carrying out that treatment which, in a referral to secondary care or specialist service ,may be a long period after the initial decision to refer was taken. The referral by the dentist in general practice is made on the basis that the patient understands in broad terms the purpose, nature, likely effects risk and alternatives but with the proviso that a full assessment will made by the anaesthetist whose responsibility it ultimately is to ensure that appropriate consent has been obtained.

Nevertheless research in this area found that 66% of patients who were referred for GA felt they were not informed of any of the risk of GA by their referring dentist and 63% of letters of referral contained no reason for justification for the referral[70].

Clinical examples in dentistry

Cosmetic dentistry is by and large elective treatment and therefore any attendant risks must be explained to the patient. Veneers, for example may require large amounts of tooth reduction to be aesthetic and the patient must be advised that they would feel bulky in the initial stages. Crown and bridgework carries a risk of the loss of vitality and this is particularly true when misaligned teeth are being prepared to accept crowns. Where there is a high risk the patient must be informed to allow then to make a reasoned decision. There are strong arguments for advising the patient of the actual amount of tooth in percentage terms that would be removed in some types of preparation and the implications for pulpal health as a consequence[71]

There is much concern however that whilst the legal considerations around consent for the procedures may have been adequately satisfied, the ethics and morality of destroying sound healthy teeth for cosmetic enhancement is questionable.[72]

Patients often ask about the likelihood of success in cosmetic treatment or require some guarantees. The possibility of a contractual warranty is important since no such duty arises in negligence: the only obligation of the dentist is to act reasonably[73].

However the GDC has indicated that as part of the consent process a patient may wish to know whether the treatment is guaranteed, how long it is guaranteed for and any exclusions that apply.[74]

In any private care, a contractual relationship will exist between the dentist and the patient and the terms of that contract will be for the two parties to agree. It would be unusual to guarantee a particular outcome though certain aspects, such as the laboratory constructed items, may carry a free replacement warranty in the event of failure within a given time period.

Nothing is for life and patients may have unreal expectations about how long restorative work will last .It is incumbent on the dentist to provide sufficient information to allow a patient to make up their mind before proceeding with any particular treatment.

RECORDS

An essential part of the consent process is giving patients options to enable them to make a decision. When giving that information it needs to be in language that is easy to understand and free of jargon and leaflets are very useful to aid in this process of delivering information. Pictures, models and intra-oral images all help build up the information bank required by the patient in this consent process.

Once a decision has been it is important a clinical note is made in the records. Where more complex treatment is to be provided especially where there is a higher risk of failure or more especially when a

patient is electing for treatment which is not recommended by the dentist then providing a letter covering these points along with a written quote is essential.

PRIVATE V NHS WORK

As part of the consent process patients need to be given information about the quality of the treatment if they specifically ask. This will often arise in any discussion with a patient about the differences between NHS crowns or dentures and private ones. In some cases there is no equivalent choice available on the NHS in primary care such as implants. However for other options where there is a difference in materials , quality of fit and aesthetics the patient has a right to know the differences in an objective summary of the nature of NHS crowns, bridges and dentures. This should be an essential part of the process in which information is imparted to the patient during a consultation.

Part of NHS documentation in England is an FP17 DC form which is a written treatment plan outlining costs and is useful when both NHS and private treatment are being offered to the patient. It is a useful document but it is not a consent form.

This form also sets out the position with regards to cosmetic dentistry provision in the NHS and as part of the discussion about mixing any NHS and private services.

It is useful to refer the patient to this part of the document which says "The NHS provides all the treatment necessary to secure and maintain your oral health. There are some treatments (mainly cosmetic) that are not normally available under the NHS, and you may choose to have these provided privately.

You may also choose to have some treatment provided privately as an alternative to NHS treatment. The dentist will discuss these options with you so that you can make an informed choice"

In a study, 79% of patients mistakenly thought that signing an FP17 claim form was a consent to treatment and it appears from other studies two thirds of general practitioners also think this is the case[75]. This other form has the function of confirming the patient's agreement to pay the NHS charge, verifies that the treatment indicated is complete and allows information to be disclosed by other agencies for counter fraud purposes. It is not however a consent form and neither are any of the GDS forms.

In respect of costs the GDC makes it clear that a patient should know

- the nature of the contract and in particular whether the patient is being accepted for treatment under the NHS or privately
- the charge for an initial consultation and the probable cost of subsequent treatment
-

The GDC also sets out the parameters of offering NHS care warning registrants that they must make it clear which treatment can only be provided under the NHS and which can only be provided on a private basis (1.7.2), not to mislead the patients into believing treatments which are available on the NHS are only available privately (1.7.3) and not to pressurise patient into having private treatment when it is available to them under the NHS (1.7.4).

WHEN THINGS GO WRONG

Treatment does not always go to plan. This may range simply from a contact point in a multi-surface restoration not being tight to endodontic instruments separating in canals. It is important the patient is fully informed no matter how embarrassing such a disclosure is likely to be. The patient has a legal right to know that a particular unexpected outcome has occurred even if it was avoidable and may potentially undermine the patient's confidence in you.

DUTY OF CANDOUR

The legal duty of candour, which was introduced by the government through Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, applies to dental practices from 1 April 2015 and arose out of investigation into the events at Mid-Staffordshire NHS Foundation Trust and Sir Robert Francis Report advocating , openness and transparency as being essential n principles of healthcare when things have gone wrong.

Essentially this means that every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress[76].

The specific requirement by the Care Quality Commission to disclose information to the patient relates to a "notifiable safety incident"[77] defined as :

"any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:

(a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or

(b) severe harm, moderate harm or prolonged psychological harm to the service user."

For the purposes of the regulation, "harm" is categorised in three levels :

- Severe harm – permanent lessening of bodily, sensory, motor, physiologic or intellectual functions. This includes removal of the wrong limb or organ or brain damage. As with death, it must be directly related to the incident, and not the natural course of the underlying illness or condition
- Moderate harm – this means significant, but not permanent, and needing a moderate increase in treatment (this includes unplanned further surgery, readmission, a prolonged care episode, extra inpatient or outpatient time, cancelled treatment or transfer to another treatment area (ITU)).
- Prolonged psychological harm – psychological harm the patient experiences (or is likely to experience) for a continuous period of at least 28 days.

The GDC have signed up to the "Joint statement from the Chief Executives of statutory regulators of healthcare professionals" on openness and honesty which means that the healthcare professionals must

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong;
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family);
- offer an appropriate remedy or support to put matters right (if possible); and
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Saying sorry

Saying sorry is not an admission of liability. Clinician are often reluctant to apologise, fearing this either undermines their case, hands a moral victory to the patient or demonstrates some weakness on their part.

An apology is simply an expression that something has gone wrong or that at the very least the patient is unhappy about something and the clinician is empathising with this. It is a practical and pragmatic response and demonstrates to the patient some element of openness and the potential start to resolve or prevent a complaint arising or escalating.

Apologies are part of providing an explanation for what when wrong, they need to be sincerely and in a timely manner.[78]

It is important to appreciate that the statutory duty of candour refers to safety incidents caused through the provision of care. It does not refer to recognised

complications or undesirable outcomes that occur as part of the natural course of the patient's illness or their underlying condition[79].

It has been argued, if there is any doubt about the threshold for when it is appropriate to tell the patient about a particular adverse outcome then guidance provided by Lord Woolf [80] should be adopted. This can be transposed for the purposes of engaging the duty of candour as "If significant harm has occurred that the reasonable patient would wish to know about, then in the normal course it is the responsibility of doctor to inform the patient of that significant harm and the way it was caused"[81]

Separating instrument in canals and perforations are well recognised complications of root canal therapy. Whilst fortunately it does not occur often it is good practice to advise the patient of a risk of it occurring and especially if the canal anatomy suggests it may be a risk factor in that particular endodontic treatment. If an instrument does separate in the canal, part of the consent process is to inform the patient and advise them of the options available [82]which will include a referral to a specialist. It is equally important to record this conversation on the clinical notes confirming what option the patient took at the time.

All too often this vital piece of the jigsaw is missing and several years later when a costly referral to specialist is finally made, possibly by another dentist, the patient refuses adamantly to accept they had declined an earlier referral.

Summary

Consent is about treating patients with courtesy and respect, recognising their dignity and rights as individuals. It is a process rather than a one-off event and as the GDC describes "it should be part of an ongoing dialogue between you and the patient".

In summary, for consent to be valid the following information should be provided:

What treatment is proposed and what it involves in broad terms

Why the treatment is necessary and the consequences of no treatment

What the alternative options for treatment are and the risks associated with them

What, if any adverse anticipated risks there are

What the costs are

CHILDREN AND CONSENT

In children below the age of 16 the capacity to consent to treatment is a matter of clinical judgement based on the degree of intelligence and understanding of the child to make the relevant decision based on Gillick competence.

THE GILLICK CASE

(GILLICK V WEST NORFOLK AND WISBECH AREA HEALTH AUTHORITY HOUSE OF LORDS [1986] AC112 [1985] 3 ALL ER402

MRS GILLICK HAD FIVE DAUGHTERS ALL UNDER THE AGE OF 16. A GOVERNMENT CIRCULAR FROM THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY WAS SENT TO DOCTORS INDICATING THAT IN THE EXCEPTIONAL CASES OF A GIRL UNDER 16 ATTENDING A FAMILY PLANNING CLINIC FOR CONTRACEPTIVE ADVICE AND TREATMENT, PROVIDING THIS WOULD NOT BE UNLAWFUL AS LONG AS THE DOCTOR WAS ACTING IN GOOD FAITH TO PROTECT THE GIRL FROM THE HARMFUL EFFECTS OF SEXUAL INTERCOURSE. THE CIRCULAR ALSO SAID IT WAS PERMISSIBLE TO PRESCRIBE THE CONTRACEPTIVE PILL WITHOUT THE CONSENT OF THE GIRL'S PARENTS UNDER APPROPRIATE CIRCUMSTANCES. MRS GILLICK SOUGHT AN ASSURANCE FROM THE HEALTH AUTHORITY THAT HER OWN DAUGHTERS WOULD NOT BE GIVEN ANY CONTRACEPTIVE ADVICE OR TREATMENT WITHOUT HER PRIOR KNOWLEDGE.

The health authority declined to give that assurance and the case went from the High Court to the Court of Appeal who reversed Woolf J's decision and then subsequently on to the House of Lords-the final arbiter in the matter. The judges, including the late Lord Scarman made it clear that a child under the age of 16, who had sufficient understanding to know what was being proposed was more than capable of consenting to wide range of treatment irrespective of the parents' wishes.

As Lord Scarman declared "It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give consent valid in law. Until the child achieves the capacity to consent, the parental right to make the decision continues save only in exceptional circumstances. Emergency, parental neglect, abandonment of the child or inability to find the parent are examples of exceptional situations justifying the doctor proceeding to treat the patient without parental knowledge and consent"

More often than not children will attend a dental practice with their parents usually as a family and this is certainly something to be encouraged by the practice. It is important clinically since oral health

messages can be delivered to patient, parent and siblings equally effectively but it also ensures issues of consent for investigations and treatment can be dealt with quickly and efficiently.

Children themselves want to be involved in the decision –making process and they want this to be in the form of a discussion between the dentist, their parents and themselves. Children want adults to recognize and help promote their evolving autonomy by listening to them and acknowledging their contribution in consenting to dental care. This increases their understanding and satisfaction with their dental care[83]

In the rare cases of child abuse when oro-facial signs may give rise to suspicions, dental practitioners have an ethical and moral duty to investigate the matter and consent becomes a matter of importance.

When is a child not a child?

The first yardstick is statute law.

A) CHILDREN AGED 16 AND 17

Until a person has reached their 18th birthday they are considered a minor by the law. In England and Wales (but not Scotland) The Family Law Reform Act 1969 sets out the position for 16 and 17 year olds.

"the consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age [i.e. aged 18 years or above];and it shall not be necessary to obtain any consent for it from his parent or guardian".

This means that in many respects they should be treated as adults-for example if a signature on a consent form is necessary, they can sign for themselves [84] if they are deemed competent.

The test for competency/capacity is the same for adults as described above.

It is still good practice to encourage competent children to involve their families in decision making processes and where treatment incurs charges to the patient this is doubly so.

If a 16-17 year old patient refuses consent for treatment that is considered to be in the patient's best interest, the Family Law Reform Act 1969 allows a person with parental responsibility to give proxy consent. In reality it would be very difficult to physically force dental treatment on a competent 16-17

year and since in most cases not providing dental treatment would not be life threatening, it would not justifiable.

If a child of 16 or 17 is not competent to take a particular decision, then a person with parental responsibility (see below) can take that decision for them, although the child should still be involved as much as possible.

When a child reaches the age of 18 they are an adult under the law and no-one can make a decision on their behalf if they are deemed to have capacity.

B) CHILDREN UNDER 16

The second yardstick for deciding whether a child can give consent is measured against the Gillick case (above), which arises from common law.

This allows the dentist to provide treatment in the patient's best interest, in the absence of parental permission, where the patient is assessed as "Gillick competent" and the child has given consent for the procedure.

The term 'Fraser competency' is also used in this respect and is sometimes incorrectly used interchangeably with "Gillick " competence. As one of the Law Lords responsible for the Gillick judgment, Lord Fraser specifically addressed the dilemma of providing contraceptive advice to girls without the knowledge of their parents.

The summary of his judgment referring to the provision of contraceptive advice was presented as the 'Fraser guidelines' and therefore Fraser guidelines are narrower than Gillick competencies and relate specifically contraception[85]

With regards to assessing the child's ability to provide consent Lord Woolf said

"...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent." [86]

Case law has not shed much light on assessing Gillick competence leaving the dentist to decide whether the child has sufficient understanding and intelligence to enable him or her to fully understand what is being proposed. Where interventions are minor, such as fissure sealants, it is easier to presume competence. Where, for example, choices are available such as amalgam versus

composite fillings and parents may have concerns about certain types of restorations or extractions are required it is better to discuss this with the parents together with the patient.

Orthodontics is an important area where sometimes complex treatment is provided to this age group and a full discussion with a person who has parental responsibility is important. If a Gillick competent child under 16 refuses orthodontic treatment, which they are entitled to do so, even under the Children's Act 1989, it would be unwise to override that consent at the parents insistence since long term patient co-operation is a significant aspect of successful orthodontic treatment.

There is debate about the moral imperative of parents to look after their children with the right to determine their welfare and an underlying duty to do so. This balance comes into conflict in matters of sexual health for example but the courts are clear that "the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed"[87]

Since the assessment of Gillick competence is a developmental concept and can vary considerably, no age bands are given as guidance though it is unlikely that the courts would consider children of 13 years or less to be Gillick competent in most situations[88]

Refusal of treatment

If a parent or someone with parental responsibility refuses treatment that a dentist believes is appropriate a Court may be asked to decide what is in the child's best interest. This would only be when providing the treatment against the wishes of the child or parent was crucial, i.e. the child would die or suffer serious permanent injury without it. Such circumstances rarely, if ever, occur in a dental practice but have occurred with the decisions around cancer treatment in children.[89]

Parents cannot override the competent consent of a young person to treatment that you consider is in their best interest. But you can rely on parental consent when a child lacks the capacity to consent.[90]

If the parents disagree about what dental treatment is best for their child, the law only requires the dentist to obtain consent from one of the parents in order lawfully to provide treatment . Disputes between parents can be difficult for everybody involved in the child's care. Dentists must take care to concern themselves only with the welfare of the child and to avoid being drawn into extraneous matters such as marital disputes. Discussion aimed at reaching consensus should be attempted. If this fails, a decision must be made by the clinician in charge whether to go ahead despite the disagreement[91], though it would be wise to discuss this with colleagues and a doffer a second opinion

if necessary . If refusal of treatment may result in significant harm to the child it may be necessary to consider whether this is a safeguarding issue

PARENTAL RESPONSIBILITY

Parental responsibility is defined in the Children's Act as being "All the rights, duties, powers, responsibilities and authority, which by law a parent has in relation to the child and the administration of his/her property".[92]

This means that a person with parental responsibility is responsible for the care and wellbeing of their child. Unless a court order says something different, that person can therefore make important decisions about the child's life, for example:

- Providing a home for the child
- Protecting and caring for the child
- Consenting to the child's medical or dental treatment
- Consenting to the child's emigration[93]

Who has parental responsibility is a key aspect of obtaining consent from a child. In many cases more than one person has parental responsibility for the child, typically the natural parents of the child, and it is important to remember that consent only has to come from one of the people who has parental responsibility. There is no obligation on the dentist to seek the consent of any other person with parental responsibility before providing treatment.

The Court can step in to act in the child's best interest to overrule the wishes of parents when requested to do so by hospitals. It may be that one or both parents object to the treatment that is being suggested and take the child away from the hospital.[94] [95]

Issues of parental responsibility often arise when either the child is brought to the practice by a grandparent, childminder or relative or when the parents are separating, and the oral health, of the child, or lack of it, is a matter of dispute.

Where there is disagreement between parents about what treatment should be provided, one consenting and the other refusing, the dentist "will be presented with a professional and ethical dilemma but not with a legal problem because if he has the consent of one authorised person, the treatment will not without more constitute a trespass or criminal assault"[96]

In other words, in the event of a dispute between the parents regarding a particular dental treatment option, the dentist need only obtain the consent of one of the parents who has parental responsibility.

The Children Act 1989 sets out who has parental responsibility and these include

1) the child's mother
2) the child's parents if married to each other at the time of conception or birth
3) the father:

a) only if he was married to the child's mother at the time of conception or birth

b) if not so married, then he only has parental responsibility <u>if</u> he has acquired it via a court order (parental responsibility order) *or* a "parental responsibility agreement" with the mother *or* he subsequently marries the mother *or* he is named on the child's birth certificate after 15 April 2002 in Northern Ireland, 1 December 2003 in England and Wales and May 2006 in Scotland.ie he does not have to be married to the mother to have parental responsibility after these dates as long as he is named on the birth certificate

4) the child's legally appointed guardian-appointed either by a court or by a parent with parental responsibility in the event of their own death
5) a person in whose favour a court has made a residence order concerning the child
6) a local authority or other person who hold an emergency protection order in respect of the child.

The child's biological mother will always have parental responsibility for her child regardless of family structure but the civil partner of the biological mother can get gets parental responsibility if

-she and the mother were in civil partnership at the time of the child's birth

-their name is registered on the birth certificate

- the civil partner entered into parental responsibility agreement with mother

-obtained court order for parental responsibility

-has residence order

Where a child's parents who have parental responsibility for the child is married to, or is in civil partnership of a person who is not the child's parent (the step parent) they may acquire parental responsibility by

-making an agreement with the parents(s) with PR that the step parent will have PR or

-a PR order is made by the court on application by the step parent

Parents do not lose parental responsibility if they divorce – neither can a separated or divorced parent relinquish parental responsibility. This is true even if the parent without custody does not have contact with the child and does not make any financial contribution[73].

Parental responsibility cannot be surrendered or transferred but the person with parental responsibility can arrange some or all of it to be met by one or more people acting on his or her behalf. Thus, for example, parents might give authority to grandparents or a childminder to give consent under defined circumstances such as dental treatment. Where such explicit authority has been given, and it need not be in writing, the consent of the person with the authority will be valid and there is no duty on the dentist to try and contact those with parental responsibility as well, unless you have reason to believe that the parents view might differ.

Under Section 3 of The Children Act 1989 a person who does not have parental responsibility for a particular child but has the care of the child may do what is reasonable in all circumstances of the case for the purpose of safeguarding or promoting the child's welfare. Thus, a child who has fallen over in the playground and suffered trauma, might be brought to the practice by a teacher when a parent cannot be contacted. It would be lawful for the dentist in this situation to provide treatment in the child's best interest and no one with parental responsibility could be contacted, even if the teacher has not been given explicit authority to consent on behalf of the parents.

Looked after children

Under Section 31 of the Children Act 1989, a council can take a child into care if it believes the child is suffering or at risk of suffering significant harm. They can also become a looked after child and or "accommodated" under section 20 of the Children Act 1989

If a child is taken into local authority care on a care order, parents share parental responsibility with the local authority for consent for medical treatment but if the child is in voluntary care, the local authority has no parental responsibility.

The parents will lose parental responsibility if a child is adopted. Parental responsibility can be restricted by court order[86].

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