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To: All Registered Dental Professionals

Urgent Advisory to All Healthcare Professionals

On 11 March 2015, the UK Supreme Court issued a landmark decision in which the Court determined that what medical professionals are expected to tell a patient when obtaining the patient's informed consent for treatment should no longer be based on accepted medical practice.

Instead, the standard of care is based on *what a reasonable patient in that position would expect to be told*. Our legal advisors have informed us that there is a likelihood that Singapore may eventually adopt the same legal position, and if so, this will have a major impact on how dental professionals approach a discussion of risks with their patients. Dental professionals need to ascertain the patient's concerns, address the patient's queries, and ensure that information that would be regarded as being material to the patient's deliberations whether to undergo the treatment, are properly conveyed.

We would therefore like to remind all dental professionals of the following:

1. It is important to engage your patient, and provide sufficient time to talk to the patient. What you are expected to tell a patient should no longer be based solely on the practice of your peers, nor should you assume that all patients require the same level of information. If you have any concerns that the patient may need more time to decide, or have other queries, the patient should be given time to consider before signing the consent form.
2. Alternative treatment options need to be discussed even if they are not considered to be the medically preferred option. It is not appropriate to withhold information on alternative treatments out of concern that the patient may decide not to opt for the recommended treatment. This may expose the dental professional to allegations that the material risks or information were not shared and hence there was no informed consent.

3. It is extremely important to document your discussions with your patient, as this will help you in the event of any dispute.
4. Attached is a summary of the UK case, for your information.

Yours sincerely,

Clin A/Prof Patrick Tseng
Registrar

(This is a computer-generated notice which requires no signature)



11 March 2015

PRESS SUMMARY

Montgomery (Appellant) v Lanarkshire Health Board (Respondent) [2015] UKSC 11
On appeal from [2013] CSIH 3

JUSTICES: Lord Neuberger (President), Lady Hale (Deputy President), Lord Kerr, Lord Clarke, Lord Wilson, Lord Reed, Lord Hodge

BACKGROUND TO THE APPEAL

The appellant, Nadine Montgomery, gave birth on 1 October 1999 at Bellshill Maternity Hospital, Lanarkshire. As a result of complications during delivery, her baby was born with serious disabilities. Mrs Montgomery sought damages on behalf of her son alleging negligence of the respondent Board's employee, Dr McLellan, who was responsible for her care during her pregnancy and labour. Mrs Montgomery has diabetes. Women with diabetes are more likely to have large babies and there is a 9-10% risk of shoulder dystocia during vaginal delivery (the baby's shoulders being too wide to pass through the mother's pelvis). Though this may be resolved by emergency procedures during labour, shoulder dystocia poses various health risks to the woman and baby. Mrs Montgomery had raised concerns about vaginal delivery but Dr McLellan's policy was not routinely to advise diabetic women about shoulder dystocia as, in her view, the risk of a grave problem for the baby was very small, but if advised of the risks of shoulder dystocia women would opt for a caesarean section, which was not in the maternal interest.

Following the decision of the House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985], the Lord Ordinary held that whether a doctor's omission to warn a patient of risks of treatment was a breach of her duty of care was normally to be determined by the application of the "Bolam test" (*Bolam v Friern Hospital Management Committee* [1957] i.e., whether the omission was accepted as proper by a responsible body of medical opinion, which could not be rejected as irrational. Given the expert medical evidence for the Board, the *Bolam* test was not met. The Lord Ordinary accepted that where treatment involves a "substantial risk of grave adverse consequences", in some cases a judge could conclude that a patient's right to decide whether to consent to that treatment was so obvious that no prudent doctor could fail to warn of the risk. In the Lord Ordinary's view, the risk of shoulder dystocia, though significant, did not in itself require a warning since in most cases shoulder dystocia was dealt with by "simple procedures" and the chance of a severe injury to the baby was "tiny". Following *Sidaway*, he also noted that if a patient asks about specific risks, the doctor must answer, but did not accept that Mrs Montgomery asked such questions.

The Inner House of Session refused Mrs Montgomery's reclaiming motion and upheld the Lord Ordinary's conclusion. Since both courts held that no duty owed was to her, the issue of causation did not arise. Both nonetheless held that Mrs Montgomery had not shown that, had she been advised of the risk, she would have elected to undergo a caesarean, thus avoiding the risks to the baby.

JUDGMENT

The Supreme Court unanimously allows the appeal. Lord Kerr and Lord Reed give the lead judgment with which Lord Neuberger, Lady Hale, Lord Clarke, Lord Wilson and Lord Hodge agree. Lady Hale gives a concurring judgment.

REASONS FOR THE JUDGMENT

Lord Kerr and Lord Reed find that since *Sidaway*, it has become clear that the paradigm of the doctor-patient relationship implicit in the speeches in that case has ceased to reflect reality. It would be a mistake to view patients as uninformed, incapable of understanding medical matters, or wholly dependent on information from doctors. This is reflected in the General Medical Council's guidance. Courts are also increasingly conscious of fundamental values such as self-determination. [74-80] Societal and legal changes point towards an approach to the law which treats patients so far as possible as adults capable of understanding that medical treatment is uncertain of success and may involve risks, of accepting responsibility for risks affecting their lives, and of living with the consequences of their choices. This entails a duty on doctors to take reasonable care to ensure that a patient is aware of material risks inherent in treatment. Further, because the extent to which a doctor may be inclined to discuss risks with patients is not determined by medical learning or experience, applying the *Bolam* test to this question is liable to result in the sanctioning of differences in practice attributable not to divergent schools of thought in medicine, but merely to divergent attitudes among doctors as to the degree of respect owed to their patients. [81-85]

Lord Kerr and Lord Reed reason that an adult of sound mind is entitled to decide which, if any, of the available treatments to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in proposed treatment, and of reasonable alternatives. A risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it. Three further points emerge: first, assessing the significance of a risk is fact-sensitive and cannot be reduced to percentages. Second, in order to advise, the doctor must engage in dialogue with her patient. Third, the therapeutic exception is limited, and should not be abused. [86-91]

In the present case, Dr McLellan ought to have advised Mrs Montgomery of the substantial risk of shoulder dystocia. The Court of Session focused on the relatively small consequent risk of grave injury to the baby. However, shoulder dystocia itself is a major obstetric emergency; the contrast with the tiny risks to the woman and baby involved in an elective caesarean is stark. [94] On causation, the courts below had in mind the supposed reaction of Mrs Montgomery if advised of the minimal risk to the baby of a grave injury consequent on shoulder dystocia. The lower courts should have focused on her likely reaction if advised of the risk of shoulder dystocia itself. Dr McLellan's unequivocal view was that Mrs Montgomery would choose a caesarean if so advised; indeed that is precisely why she withheld that information. [101, 103] The Lord Ordinary considered the doctor to be an impressive witness. The only reasonable conclusion is that had Dr McLellan discussed dispassionately with Mrs Montgomery the risk of shoulder dystocia, the potential consequences, and the alternatives, she probably would have elected for a caesarean section. [104]

Lady Hale reasons that it is impossible to consider a particular procedure in isolation from its alternatives. Pregnancy is a powerful illustration. Where either mother or child is at heightened risk from vaginal delivery, doctors should volunteer the pros and cons of that option compared to a caesarean. We are concerned not only with risks to the baby, but also risks to the mother. [109-114] Dr McLellan's view that caesareans are not in maternal interests is a value judgment; once the argument departs from purely medical considerations, the *Bolam* test is inapposite. A patient is entitled to take into account her own values and her choices must be respected, unless she lacks capacity. She is at least entitled to information enabling her to take part in the decision. [114-115]

References in square brackets are to paragraphs in the judgment

NOTE

This summary is provided to assist in understanding the Court's decision. It does not form part of the reasons for the decision. The full judgment of the Court is the only authoritative document. Judgments are public documents and are available at: <http://supremecourt.uk/decided-cases/index.shtml>