Consent – how should I consent a sportsman after Montgomery?

Montgomery – the law on Consent

The Supreme Court decision in *Montgomery v Lanarkshire Health Board* is of importance for all medical practitioners on the issue of obtaining a patient's informed consent. It is no longer acceptable for the medical practitioner to take a "doctor knows best" approach to consent. For clinicians providing treatment to professional sportspeople, often in a high-stakes and pressured environment, it is of paramount importance that the patient is sufficiently counselled. If an injury does not resolve, or if surgery is unsuccessful, often a claim may be brought against the clinician where it may be alleged that the athlete was not made aware of all risks (or all alternatives to treatment).

In the *Montgomery* case itself, leading up to the birth of her baby, the Claimant was not informed of a 9-10% risk of her baby suffering from shoulder dystocia during the delivery. She claimed that had this risk been explained to her, she would not have proceeded with a normal delivery and would have asked to undergo a caesarean section (thereby avoiding the risk that occurred).

The Supreme Court held that a doctor is under a duty to take reasonable care to ensure that the patient is aware of any "material risks" involved in any recommended treatment and of any reasonable alternative treatments. Whether a risk is "material" depends on whether a reasonable person in the patient's position would be likely to attach significance to the risk, or whether the doctor is (or should reasonably be) aware that the particular patient would be likely to attach significance to it.

This means that doctors are expected to discuss not just the risks they would expect most patients to need to know about, but also the risks that would be important to that particular patient. This is where particular considerations will apply to doctors treating sports professionals, as different risks and issues may apply than with a similar treatment to a member of the general public. Does the patient need to undergo surgery now? What are the risks of waiting – both to any short-term or long-term effects? How will the treatment impact on the patient after their career has finished? As clubs and associations become more involved and bring influence towards decisions about a player's healthcare, so doctors are under a greater responsibility to ensure that the patient him or herself understands the risks posed by a course of treatment.

Risk Management - Implications

This decision has been anticipated as resulting in an increasing number of claims, but it need not be seen as a fundamental change to the law around consent.

GMC Guidance

Indeed, the GMC Guidance, both a) *Consent – 2008 and b) Good Medical Practice – 2013*, which emphasises the need for an informed discussion based on a partnership with the patient, was seen by the Court as requiring a "broadly similar approach".

This Guidance tells clinicians that they must identify potential adverse outcomes. This includes a serious adverse outcome, even if the likelihood is very small, and less serious side effects or complications if they occur frequently.

Clinicians should ensure that they are aware of and are up to date with the GMC Guidance. The GMC regards the decision in *Montgomery* as bringing the law up-to-date with good medical practice.

Another day, another guide

In November 2016, the Royal College of Surgeons issued a publication, "Consent: Supported Decision-Making – a guide to good practice".

As well as restating the above principles, this guide emphasises the need for time – time should be set aside to allow for a quality discussion about the treatment, as the discussion must be tailored to the individual patient. It is also worth noting that the surgeon responsible for providing treatment remains

responsible for making sure that the patient has been given enough time and appropriate information to make an informed decision, and has given their consent before they start the treatment. This is particularly important if the surgeon responsible for the patient's care was not able to have the discussion with the patient.

Practical Steps

The following are practical steps and best practice which should be taken to reduce the risk of patient challenges, complaints, and ultimately claims:

- Always record your pre-operative discussions with patients and make sure that the records are as accurate and comprehensive as possible.

- Do not just say: "We have discussed the risks and complications and the patient has agreed to proceed". Record what you discussed – which risks and complications in particular.

- Remember that the patient should be told not just about the risks and complications of the proposed treatment, but also the alternatives to treatment. This may be to offer no treatment at all. This may be the risks of treatment taking place a) now, or b) in the off-season. Again, ensure that you have recorded the fact that you have discussed the alternatives.

- If you have given a patient an information sheet or guidance booklet – record that you (or a colleague) have given the patient this. Remember to keep copies of any information sheet given to the patient in case this is needed for later reference.

- Ensure that the patient signs (and dates) to record that he/she has received a particular information sheet.

- A "material risk" is more than theoretical, background or negligible. You do not have to discuss theoretical risks and complications.

- What is not material to one patient, might be material to another. Some patients will attach significance to a particular risk that others would not. It is for you to judge this in your discussions. If you think that certain risks exist, but are unlikely to be material to this patient – record this.

- If you provide information sheets or literature to patients, make sure that it is user friendly.

- It is always good practice for you and the patient to sign a "consent form". This is there to evidence (again) what you have discussed. It is helpful for the patient to sign or initial to say that they have been made aware of particular risks. They could sign in several sections, as well as sign an overall declaration that they understand the form, have been given an opportunity to discuss any issues with their treating clinician, and have told their clinician whether any risks and complications are significant or not for them.

- Please ensure, however, that information about the treatment is given at a different time to the signing of the consent form. This avoids the potential allegation that the patient was "ambushed" into signing the form.

- Do not just use a consent form as a "checklist" or tick-box exercise. The law and GMC guidance reiterate that the process of obtaining a patient's consent is precisely that – a process – which involves a genuine partnering discussion with the patient, as opposed to patients simply being passive recipients of information.

- Finally, ensure that you have good documentation retention policies and procedures in place for the holding and storage of your records. You may be asked to comment on your records several years later.

If you have any queries, do not hesitate to contact:-

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