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Communication and Consent - Ref 155STSH

with Sarah Tribe and Sandra Harding

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TRANSCRIPT

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Steven Bruce
We're gonna be talking this evening about communication and consent. So that is Osteopathic Practice Standard A, which of course is now compulsory for our three-year CPD cycle, and sections E and F of the Chiropractic Code and equally important for chiropractors. As we understand it from both general councils getting the communications and consent wrong is the biggest cause of complaints and the biggest cause of sanctions against practitioners. So, it's absolutely vital we do everything we can not to fall foul of those procedures, those principles. And to that end, I've got two experts in the subject along this evening for our virtual conference. I have Sarah Tribe and Sandra Harding. Welcome, ladies. Good evening. Sara and Sandra, they're both physiotherapists and they have made it their business to advise people on how to get things like communications and consent right. And your business is called HCPG. Did you want to tell us a bit more about yourselves and about that business, Sandra?

Sandra Harding
Of course. Thank you very much for inviting us tonight, Steven. HCPG, why HCPG? HCPG is simply healthcare professional governance. And Sarah and I as you've just kindly said, we're both physios by background. And we've both spent quite a long career in physiotherapy, during which time we've audited numerous clinics. And what we found is this overriding theme of unconscious incompetence coming from clinics, where they just didn't know what they didn't know about the standards. And so, what we're looking at is we're saying the standards and the regulations out there are good, the HCPs see what's out there, whether it be the physio, whether it be, as you said, a chiropractic or whether it's the osteopaths. But what we found is people have difficulty in interpreting what were they actually asking for? And if there was an issue and you need to provide evidence, what would it look like? So, we decided we would actually make a business out of it. So, after working for a large, independent healthcare provider, we came to a time when we wanted career changes, we went to do other things. We both then wanted another change, ironically, at the same time, we decided to come together again, and start this profession, because we love compliance, we know people don't always find it interesting and exciting. We're passionate about it. We think it absolutely underpins everything we do. And it's really important to everyone's business. And we've just built a career in it. And I think hopefully tonight, you'll find a little bit more about certain aspects, how we enjoy it. We talk about kitchen in a restaurant. Shall I share that, Steven with the listeners?

Steven Bruce
Yeah, please do.

Sandra Harding
So how we describe ourselves is we say many clinical professions are very focused on the front end of the business and the outcome measures. We think of that as the restaurant. They're all about getting great food, great, quick food, hopefully getting the Michelin star or all those rosettes. But actually, if the kitchen isn't safe and gives you diarrhoea, you're not going to maintain that rosette. Sarah and I see ourselves as we are in the kitchen, working with you getting all those foundations in place. Thing is that most clinicians aren't interested in that part of it, they're all about the treatment. We're actually the bit that sits behind your treatment. Are you following the standards? Is it robust? And if something goes wrong, have you got the

evidence to mitigate some of the risks? So, we talk about the kitchen and the restaurant, we're trying to give you the scores on the doors for the kitchen to mean you get the Michelin star at the front of house.

Steven Bruce
I'm really pleased that you've given up your time to be here this evening. I doubt that we have any people watching this evening who don't think they can learn from other professions. Because I think one of the dangers in the chiropractic and the osteopathic professions is that we are quite insular, we tend to work alone or we tend to work in small groups of like professionals. And it's the reason of course, why osteopaths and chiropractors have to do this learning with others is to force us to get out there and meet other people. Physios, I think you have a wider background of professional colleagues, because for many physios the NHS is the starting point of your careers, isn't it? So, you're working across a wide band of different professionals. I like that term unconscious incompetence, because I think sometimes, we need to have it drawn to our attention that we think we're doing things brilliantly, but we only do that on the basis of what we know and therefore there may be things missing. And I think that you and I, both of you and I have things in common here because as you say most people want to focus on the kitchen and on the food delivered. But just as I'm concentrating on delivering good quality CPD and doing the admin for people behind the scenes where I can, you're doing all those other things behind the scenes that the practitioners don't want to do. They just want to get in and fix patients and that's what we're trying to help them to do here, isn't it? Now, Sondra, in my notes it says you're going to talk about communication and Sarah, you're going to talk about consent. Is that because you know those things, or is that because you just wanted to divide it up?

Sandra Harding
Just seemed sensible to divide it up. But we'll chip in and we'll share things together because that's how we work.

Steven Bruce
And I should point out too, that I know you do work with osteopaths, at least because it was Deborah who referred, Deborah's names gone out of my head. Deborah Smith, who referred you to us and Deborah from Mint, the osteopathic practice, which deals in similar things to what you've mentioned. So, talk to us then Sandra about communication. Because there's a lot in the chiropractic code about communication, there's quite a bit in the osteopathic practice standards about how we've got to get it right with patients, adapt our communication to suit their needs, how do we make that happen in real life?

Sandra Harding
I think the thing that when you look at, irrespective of which clinical profession it is, there's some real key themes coming out from whether it be as you said, whether it's Quality Statement 8 from the Royal College of Chiropractors, whether it's Principal F, whether it's the quality assurance standards for physios, whether it's the HCPC standards of proficiency aspect, whether it's Theme A, the thing that's coming out from all of them is that that communication and that patient partnership is absolutely key. And I think the thing that is really important this so many complaints are driven by poor communication or issues around

communication or mismanagement of an expectation, again, due to communication. So, I think there's some sort of key things with communication. And obviously, one of the first ones is the whole piece about listening. And the important thing about listening is that we always say to people, and we do some training around this as well is, do you really listen? We've got two ears and one mouth and when I was little, I was always told, that's the proportion we should be using them in. So, you listen twice as much as you speak. And when we listen, one of the common themes that comes out, the best thing to make sure we're doing is we're summarising, we're going through what we've explained, we're making sure it's clear, because so often I think we find as clinicians is sometimes what you think you've said, isn't exactly what the patient or client brings back to you. So, it's making sure not making any assumptions that they have understood it. It's simple things, but so often, it's as simple things we get wrong that cause us issues. And so, if you give an action plan and make sure that the patient is really aware of what the plan is, that they've been involved in it, they know what's happening and they fully understand it. Another really important part when we're talking about communication, is trust, and making sure that we've got that trust. And the reason why we need the trust is actually if you can build that trust, you have a better perception of care. And there's also evidence showing that there's a better acceptance and adherence to what you're suggesting, if you've actually built the trust. And also, it decreases someone's anxiety. So, they're two of the sorts of whole areas to talk about when you're first starting with communication, and kind of mentally thinking about it starts the minute someone sits down. How do you communicate to an individual when they enter your practice? Do we think that that patient, that client, whatever phrase you use, they probably feel like they're coming into an operating theatre? They might even feel like they're already in the theatre. How welcome do we make them feel? How well do we communicate to them when they enter? So often, patients will talk about, I don't feel somebody really saw I was there. And I know it's different at the moment where there isn't as much face to face going on. But seeing the top of someone's head all the time is not really conducive to communicating very well. That patient is probably feeling very vulnerable. Do we try and communicate that we understand and that we empathise with them? And that actually we reassure them? And it starts the minute they walk in. Does your waiting room welcome a patient? Do we actually manage that expectation? When they come in? People expect a smile. Do we show them where things are? There's the toilets, there's the coat hook. It sounds really obvious, but very often, communication issues start with the simplest things going wrong, and then they can escalate from there.

Steven Bruce
Have you got any examples from, probably more from the HCPC than anywhere else, but examples of simple communication issues that have led to some nasty events for the practitioners?

Sandra Harding
I think the thing that we've found and one of the things that we've been looking at recently and I'll use osteopaths here, because we've been working with them most recently, as you said, is that in a lot of their research, what they've shown is osteopaths are quite good at making people feel at ease and showing care and compassion. But they're often not as good about the action plan, letting the patient take control, fully understanding and being positive about what they deliver. And that can then mean there's a mismatch in the patient's understanding. So that can generate your complaints, which obviously, then can, you know, there's

a whole communication piece that Sarah will come on to when she talks about consent, about explaining what you're doing. And there's instances with the HCPC where patients didn't expect what came because the communication wasn't very good. One of the things that Sarah and I always say is never take a patient by surprise. Make sure you've communicated in such a way that they understand what is coming, because taking a patient by surprise is often a route to some of the things that you see coming up and being reviewed by the professional registration committee.

Steven Bruce
How do you feel about electronic note taking? Because in our clinics, in the old days, I could look my patient in the eye and write my notes and probably make a fairly good fist of being able to read them afterwards. If they come in now, and I'm taking notes electronically, I imagine that maybe lots of practitioners who are typing contemporaneously will have their head down over their screen. Surely that interferes with the communication process?

Sandra Harding
I think absolutely. I think it can. I think this is why we come back to the thing that I was saying at the beginning is that because the engagement is very different when you're looking down as opposed to looking straight at them. So, I think that's why we need to come back to make sure we've really listened. And we summarise and clarify what we've gone through and make sure that we've listened to hear, not listened to reply. And I think that's really key, is that making sure we have listened to hear. And I think we really should be repeating it because it is more difficult now when the emphasis is just getting the electronic notes populated.

Steven Bruce
I've had one question in already from Trevor, actually. I think, to be honest, this is probably a wider political question outside the scope of our discussion here but thank you anyway, Trevor. He says he'd love to hear your views, both of you about the need for freely given informed consent to any medical procedure and how that gels with the government's proposals regarding denying access to some services or venues without production of a vaccine passport. This could easily develop along the lines of China's social credit system, which I'm not familiar with, and I don't see much evidence of informed consent there. I'm not sure I see how informed consent has anything to do with your access to the service in the first place. But any thoughts?

Sandra Harding
I think it's a tough one. I think it's would probably bring up an awful lot of politics. I'd imagine we've got some people jumping around in their chairs watching the screens at the moment. I think we've got to be very careful. I would agree with you. Otherwise, I think we will be going off on a tangent down here. We're talking about informed consent and the vaccine passport. Sarah, I'm not sure what you think on that.

Sarah Tribe
I agree. Yeah, I think it's an interesting question. But I think that it's probably not one for here.

Steven Bruce
I think it's probably a question more for are we denying people access to a service because of the passport rather than our ability to communicate or get consent once they're in the practice itself? So we've started on consent, so maybe I should move over to you, Sarah. You've been sitting there very quietly and waiting your turn here. There's a bit of discussion always about the difference between valid and informed consent. What should we be taking from that?

Sarah Tribe
Yeah, so we're talking again, about incompetent competence. So, when we've been auditing practices, most physios and osteopath think that by the patient signing a sheet when they come in, with a paragraph that says, I consent to treatment, that by signing it, it's done. They've got consent, that's it, they don't need to bother again. And that's so far from what informed consent and valid consent is about. It's an ongoing process. So that piece of paper that they've signed when you first come in, wouldn't stand up in court. It's not worth the paper it's written on. It has to be informed consent has to be an ongoing process that at every stage, you tell the patient what you plan to do, what they can expect, and it must start even before they walk through your clinic door. So, for example, we really do advocate that there is a patient information leaflet that is sent to the patient when they first book their appointment, stating that there may be a need to undress, so to wear suitable underwear, that they will have everything explained to them by their therapist and they can say no at any point. Because when patients come in, as we know, they're very vulnerable and they do tend to do everything that they're told and the doctor is right and the physio is right and the osteopath's right and the chiropractor. And again, it's about empowering them to say, hold on a minute, I don't think I want to have this done. So informed consent goes on all the time, from the beginning, before they walk through the door, right through every treatment session. So, it's not even at the beginning of the treatment session that you say, have I got your consent for treatment, it's about you must explain everything that's going to happen. Is that okay?

Steven Bruce
That's all very well. And I like to think that we all do that. But the big issue is about recording consent. And this question will come in, if I don't raise it now, I know. If someone comes into me and I want them to undress and I want to touch them to do some passive examination and I want to do some soft tissue work and I want to do some, I don't know, some high velocity techniques or something else or maybe some provocative tests. Sure, I'm going to tell them what I'm going to do. And I'm gonna say, is that all right with you? And they'll say yes, generally. But if I have to write this down in my notes every single time, I've done something that's a bit long winded.

Sarah Tribe
Well, if you write down VCO, verbal consent obtained, okay, that signifies that you discussed throughout the treatment session, how the treatment may progress and allowed the patient the opportunity to discuss matters with you. And you need to record the key points raised in your clinical notes. So, you don't need to keep writing down VCO, VCO, VCO, you just need to do it once and that covers you. Then you need to

have an informed consent policy as well to back it up. But that then signifies that you have discussed the risks and the benefits with them and the complications and given them an opportunity to say no, but it's about having in the back of your mind, about what you're actually asking them for. And it's not a case about writing everything down. It's just about key points.

Steven Bruce
I always feel that, and in my clinic, we have a tick box on the electronic form saying that verbal consent was obtained, it's not so much about that itself being proof to some tribunal or PCC, Professional Conduct Committee, later that you did get the informed consent, but it shows that you are thinking along those lines, because you have considered it because you physically had to tick the box in your form. But I am still, you've said that I've got to record the key elements of my informed consent, well, my informed consent will be exactly the same for every patient. I'll be telling them about the risks and relative benefits of the different treatments that I'm about to apply to them. Surely, I don't have to write that in every single set of notes?

Sarah Tribe
If you have got things that you routinely say to your patients, so these are the benefits, risks and complications, and they don't vary too much, then what you can do to go alongside your informed consent policy, you can have a template with all of the things that you discuss with your patients. So if it ever went to court, you could say yes, I did gain verbal consent and these are the things that I discussed with them. And you as a professional will be taken that that is what happened. So you can, if it is a case that they are all the same, then you can certainly document it. And then if there's anything outside of that, then just document that one thing extra to it.

Steven Bruce
Right, okay. You make it sound there as though this is an exercise in making sure you're going to be able to beat the court when you get there, which, frankly, I suspect it probably is a little bit.

Sarah Tribe
Well, it's going to be a patient saying I didn't agree to that form of treatment. So it's about making sure that you have done everything within your power to the regulations and standard to make sure that you have tried to explain to that patient exactly what's going to happen. For example, there was a complaint- I don't know whether, Sandra, do you want to come in with this one, about the straight leg raise?

Sandra Harding
Yeah, I can bring this up. This was an instance when I brought a legal expert to come and talk to the team that I was managing at the time. And I asked them could they bring an incident that had happened with a healthcare professional with patients, something they'd looked into. And this patient had actually gone to a solicitor to seek advice regarding assault, because they come for treatment and the therapist had done a straight leg raise on them. They said they felt very vulnerable, their legs were in the air, they were in their underwear, and they didn't get the chance to say no. And the solicitor said it could be deemed to be assault, because that conversation hadn't happened. Now we all know a straight leg raise is a testing procedure that's

often used as is hip abduction. But then the message that the legal person very clearly gave was, you gave that patient a surprise, they didn't know, you didn't tell them what was happening, they didn't have the opportunity. And so, you've got to make sure that you're talking through as you're doing it, because by saying that you've obtained their consent means you're having the conversation, as Sarah said, that you're sharing it with them, you're giving them the chance to say no, and they know what is happening. The patient said, when they left, they were in a state of shock and they felt violated.

Steven Bruce
Gosh. Guilty as charged, M'lud, because I don't think I've ever attained proper consent for a straight leg raise test. I've told people what I'm about to do, but it hasn't occurred to me to ask them whether they're happy for me to do it. Well, maybe... Well, I certainly haven't gone into it in detail. I would, of course, always have covered a patient with a towel, so perhaps they would have felt less exposed that way and I don't know if this patient was in that situation. But that's very interesting, isn't it? Because there are lots of tests, I suspect where similar problems could arise.

Sandra Harding
The feedback, Steven, was what should have happened, he should have explained as they were talking and just said are you comfortable that I do this, I'm going to take your leg up into the air, etc. Just talking as you're doing and giving them the chance to stop. But to be fair, your response is exactly the same as most of the room that was there that day, we all said, we don't do that. But as I say, he came with a case, as we asked him to bring, and that's what he brought to us.

Steven Bruce
I've got a few questions already coming in. But I just wanted to go back, Sarah, to what you said about having an informed consent policy. I suspect there's a lot of people shaking their heads in the audience, the minute we start talk about policies, because they think, I've got to go write something else down. That means I've got to come up with the words. And literally it is an exercise of writing and then sticking on a shelf somewhere and never looking at again. How do you propose that we construct or store or make sure everybody's read our informed consent policy?

Sarah Tribe
So, an informed consent policy is actually very detailed. And it goes into why it's important to gain informed consent, it will also talk about Montgomery versus Lanarkshire Health Board 2015 case, moving from the Bolam test to the Montgomery test. So, you understand what the Bolam test was, this is what this reasonable practitioner would provide. The Montgomery standard, which is what the patient wants to know. So, it's really important that you understand that change in legislation because Montgomery, I'm sure you know that this was a lady who delivered her son vaginally, and she was of small stature and diabetic and her son was a big baby. And they dislocated the shoulder to get the baby out and he then had hypoxia and ended up with cerebral palsy. And the lady, Montgomery, sued and won because the risks and complications had not been discussed with her. And if they, had she said she would have opted for caesarian. So, it's really important that you tell the patient everything that they need to know, not just what you think they need to know. So,

your informed consent policy has to go through all of that. You have to know what capacity is, you have to make sure your patients have capacity. What does that mean? What's the three-stage test? Okay, you need to understand what capacity is and what 16- and 17-year-olds can and can't consent for. So. there's a whole piece that needs to be written down. So, there is your evidence, I've got this policy, I really understand the Montgomery, the Bolam, the capacity, all of those things. I get verbal consent from my patients, they have a patient information leaflet, they know what to expect, that they will be expected to undress and that they can have a chaperone if they wish to. So, it's all about thinking about sort of really sort of belt and braces so that no patient is taken by surprise. And so, this policy is not a dry, dusty thing that sits on a shelf that you think oh god there it is. You know it's about a living document. These are your foundations in your kitchen. This is really getting your kitchen into the shape that it should be. So, it's important to have a policy. And it's important to understand what verbal consent obtained actually means.

Steven Bruce
You say it's not a dry and dusty document, I suspect that people are thinking, God, I don't want to have to look through the findings of Bolam and Montgomery, and we can summarise those findings for them, because it's relatively straightforward. But nonetheless, they'll say, Okay, I've got to put this together, it will sit on the shelf, and it won't get looked at for another six or 12 months, except in the case that I'm taken before the Professional Conduct Committee, in which case, I can guarantee I will know Montgomery inside-out by the time I'm in front of that committee. And again, I'm saying I don't think this ought to be a paper exercise, but we've had a question from Kerry, who says, at what point does all the paperwork become overwhelming? And she says, between sending out information about what will happen, GDPR, and she sends out information about COVID procedures and the risks of face-to-face appointment, there's a lot of paperwork before they've even met you. And I wonder too, and Sandra this may be one for you, there is so much going out now that maybe people are inclined just to tick boxes, because they think I can't be bothered to read it all.

Sandra Harding
I think the thing, it comes back, though, to what Sarah was just saying, I think the important thing, Steven, is the processes are in place, then if an issue does arise and you're being challenged, you can say, well, these are the processes that we follow. This is what we have, this is what we understand by it. This is what VCO means. And you have all the document to back this up. And I can understand what Kerry's saying, yes, there is a lot of paper being gathered there. But the thing with the informed consent policy is if once you've written it, you really understand it, then you will be doing it. It doesn't just become a tick box, because it just becomes basically automatic. You think, have I explained the risks, have I gone through them, have I communicated properly, does this patient understand? And so, when you're ticking it, that's the process that you're naturally going through. And so, if there is an instance where you're under review, in whatever way or by whatever person, you can actually be quite clear and say, this is what I do. This is my process. And that's what we mean by making it become something that's living as opposed to just sitting on the shelf. I've done that now. I'll just write VCO. That's not understanding informed consent at all. Understanding it means you really will make sure you go through those pieces. And you're covered because Sarah and I are as much about protecting the patients and clients as we are protecting the therapist, the professional.

Steven Bruce
Apparently, my TV is going to shut down in 55 seconds. I've got to press any button apparently. Justin, this had better work. There we go.

Sandra Harding
There you go. We're back again.

Steven Bruce
I don't know who set the sleep timer.

Sandra Harding
I think the thing is, as Kerry said, the thing that I think puts a lot of people off is doing it in the beginning. But if you do it well, and you get it right, then it becomes living and breathing. And so, what Sarah and I were saying is it's getting a process that works, that you understand, that you can then articulate and bring into your own business and make it live and breathe. If it's boring and it's a bit turgid and you've just borrowed it from someone else and you don't really understand it, then yeah, it probably is gonna sit on a shelf.

Steven Bruce
I suspect I know the answer to this question, but most people who are interested in putting this policy together are going to want to know where to get the template.

Sandra Harding
Obviously, Sarah and I have a template that we use, various trusts and things have templates. They're all very similar. But the important thing is that you're covering the key themes, which is how do you do the version control? Where are the references? Who is the document for? Who needs to sign up to it? What is your process? What are you relating to? But once you've got that and you've developed that, then you can replicate that across all parts of your business. So that once you've got your template, you understand it and it works for you, then you can drop all your different policies that you need to place into that template.

Steven Bruce
So where do they get the template?

Sandra Harding
We can provide templates, we have templates, or it may be certain governing bodies have templates. There are certain professional groups that have templates. So, it's wherever is most convenient for them. But if anyone wants them from ourselves, then obviously we do happen.

Steven Bruce
Okay, I've got a question from Pip. We've talked about Bolam and we've talked about Montgomery, she has asked if one of you could talk about the implications of the Gillick hearing and Gillick findings.

Sarah Tribe
Oh yeah. So Gillick competent child. Yes. This is around capacity to give consent. So, it's quite interesting if I just talk about 16- to 17-year-olds because we will all be treating different, some people just treat children and other people may see them occasionally. So, 16- to 17-year-olds with capacity are permitted by law to give their own consent to medical, surgical and dental treatment. They do not need parental consent for therapy. You should not share confidential information about them with their parents or others unless you have specific permission to do so. Or are legally obliged. And refusal of treatment can be overridden by a parent or someone with parental responsibility. So, if they refuse, then that can be overridden, okay, but not the other way around. So, children under 16 can consent providing their Gilick competent. So, this is Gillick competency, this came about with Victoria Gillick whose daughter went to the doctor to get the contraceptive pill and the doctor didn't share that information with Victoria Gillick, the mother, because she said this child was able to understand herself. So the Gillick competent child is something, the child deals with the process of making decision based on the child's ability to understand and assess risks. So, you as a professional practitioner, you need to decide whether you think that child under 16 is Gillick competent. Some of them are, some of them aren't, but as a rule an under 13-year-old would need parental consent. So that's around the Gillick competency, and it is up to the professionals to decide whether they think their patient is Gilick competent.

Steven Bruce
How old was Victoria Gilick's daughter?

Sarah Tribe
How old was she, Sandra?

Sandra Harding
Was she 14 or 15?

Sarah Tribe
14 or 15. It was between 13 and 16. Yeah.

Sandra Harding
Something else in there, Steven, that your listeners may be interested in. Sarah, do you want to explain about, you mentioned parental consent there, do you just want to elaborate on who is who is deemed to be a parent when it comes to parental consent.

Sarah Tribe
Parental consent can be given by the mother, the biological mother, the biological father, but not a stepfather, they have to be on the birth certificate, or also anybody who has parental responsibility. And obviously a foster carer or somebody has parental responsibility, but it can only be those people.

Steven Bruce
Interesting isn't it, I think we've discussed this in a different context before, but if a young child was brought in by an adult, and the young child called that adult Mum or Dad, I wouldn't question whether they were the biological mother or father. But clearly, I should.

Sarah Tribe
Yeah.

Steven Bruce
Gosh. Someone else has just sent in, I was trying to ask this question a second ago. Sam, thank you, Sam. You talked about a three-stage competency test a little while ago, you mentioned it, Sarah, could you elaborate?

Sarah Tribe
Yes. So, for capacity there is a three-stage test. So informed consent has to meet three tests. 1) the capacity to give consent, 2) consent must be given voluntarily, and 3) the patient must be given all the information they ask for in order to make their decision. So, if you decide if somebody has capacity or not, again, you need to decide on again, the three tests. So, they to need to be able to understand what you're saying, retain the information, and weigh it up and make a decision. So as long as they can do all those three things, they have capacity, if they fail on one of them, then they don't have capacity. And then you have to make a best interest decision.

Sandra Harding
And you need to remember as well, Steven, that certain individuals may have capacity at some times of day and not others, particularly people who are suffering from dementia or maybe are on some quite heavy medication. So, these things must be taken into account when you're weighing up someone's capacity.

Sarah Tribe
And also, something like a urinary tract infection can also make people lose capacity and somebody with dementia. So, it's again, making sure because they don't have capacity, at one point when you ask them, they may have capacity again at another, so it's all about, every time you see them it's about assessing their capacity.

Steven Bruce
You said a second ago, Sarah, that you have to provide them with all the information that they ask for. But I imagine that there are certain elements of information you must provide if there's any sort of safety implications.

Sarah Tribe
Yes, you must provide everything. There is no checklist. So, there's nothing by law that says you must provide them with this, this and this. You have to make a clinical reasoned decision about what you need to tell them, you need to tell them about the risks. For example, if you do manipulation, the grade five manipulation, you do have to tell the patient that there is a risk of death. So, you really have to tell them the worst possible outcome. So, you have to make that decision yourself. And you have to talk about risks, benefits, side effects and complications. And what you may decide is actually quite a minor side effect, could be quite a big one for the patient. So, this is, for example, drowsiness might be one of the side effects of, say, acupuncture. But if you say that and don't tell the patient, that could be quite severe for them, because they come in for treatment, but then they've got to be really alert for an important meeting. So, for them, it's important that they can time their treatment, so that they are not going into work afterwards. So, it's those sorts of things, you have to tell them everything.

Steven Bruce
So, whoever treated Gwyneth Paltrow should have warned her that the cupping would leave those big marks on her back when she was about to appear on the red carpet somewhere. Yeah. You said something there, which intrigued me again, you said you had to give all the information, which sounds to me like we're getting into informed consent as opposed to valid consent. As everybody knows, there's no to the amount of information you could give about most interventions. And also, people will ask me, well, actually, not every manipulation could possibly result in death. If I manipulate your elbow, I suspect there was absolutely no chance of killing you whatsoever. Might frighten you if I didn't warn you about it.

Sarah Tribe
Yeah, so you, as a practitioner, have to decide on what you what you feel that the patient has to know. Not what you feel that's reasonable to provide, but it's actually- and give them the opportunity to ask anything.

Sandra Harding
We have, if we give an example, Steven, of when we're working with Deborah, what she was saying in her practice, is she's got her little list of the risks that she explains and the kind of way she's got used to talking about them now. And she said, it's something that, I'm sure she doesn't mind me sharing this, she said, it's good to practice talking about the risks, particularly if you don't, because again, it's getting that communication right and the way you handle it. And so, she said, when she started, she says to people to practice and one of the trainings we do say to people practice talking about the risks, till you get comfortable sharing them in such a way that patients understand but you're delivering them all quite comfortably, rather than looking as though you're afraid of talking about them, which sometimes is the case.

Steven Bruce
I'm gonna go slightly off piste here. And it's not for me to dominate the conversation, because that's why I've got you in here. But I recently took delivery of a book called The Checklist Manifesto.

Sandra Harding
We were just talking about this, Sarah and I, earlier today, this exact book.

Steven Bruce
Well, it's interesting, isn't it? Because it's written by a surgeon, an American surgeon. And one of his key examples is that surgeons are very reluctant to take on checklists, because human beings are complex, and he defines complex systems. But actually, when they introduced a checklist for applying intravenous interventions in patients, in most of the hospitals the infection rate dropped from something like 30-40% to zero. And it was purely because people had a list of things to go to and the nurses were the ones that were enforcing it. So actually, it was just having that list there and not becoming so overfamiliar with things that you think you can get away with not going through the checklist. But it's good book, isn't it? It's over there in my studio, but I'm not leaving, it's bad TV if I walk away from the camera. Can you remember the author's name, because I don't think I can pronounce it?

Sandra Harding
I can't, no.

Steven Bruce
I'll put a reference to the show and I'll send that out.

Sandra Harding
We were talking about the top five to nine items that if you were in a practice and you really wanted to get things right, what would they be? What would your checklist be? So, it's quite interesting, spooky that we were just discussing that with someone earlier today.

Steven Bruce
Beginning to sound like a Nick Hornby novel now. So, what were what were the top five that came out?

Sandra Harding
We talked about- guess what- we talked about documentation, consent, safeguarding, whistleblowing...

Sarah Tribe
Lone working.

Sandra Harding
Lone working. Yeah, these are all the things we're saying make sure you've got the processes and the policies, etc. in place for those.

Steven Bruce
Some questions from the audience. Elvina says why is a step parent not acting with parental responsibility?

Sarah Tribe
If they are the person, it has to be the deemed person, it has to be a legal, I know it sounds mad, and it is mad isn't it, Sandra, when we were talking about it, but it has to be the birth father, the biological birth father who is allowed to give consent.

Sandra Harding
It is a legal, it's not a Sarah and Sandra thing, it is literally it's legally in there. Interestingly, why? I'm not quite sure and as Sarah said, yeah, we're not sure why, but it is still there. It's listed there.

Steven Bruce
Yeah. Well, I guess we could think of examples, couldn't we, but we probably typically think of very young children. But if you were that 14- or 15-year-old we were talking about before and you didn't get on with your very new stepfather, but there are circumstances, I guess. But you implied Sarah, that they could have parental responsibility if that was agreed in law?

Sarah Tribe
Yes, well it's a bit like, if you do a best interest decision, it has to be the person that has the power of attorney for health and wellbeing is the person that can help decide in in best interests. And it's the same with giving consent, it has to be the person who has the legal parental responsibility.

Steven Bruce
Kate has asked if a grandparent or sister brings a child in could they give consent in place of the parent?

Sarah Tribe
No.

Sandra Harding
One of the things that we've discussed, Steven, that people might find interesting is a case that came up that we were discussing with some professionals. They said they regularly found that the school dropped the children off and left them for the treatment. And we were talking through this whole age, the under 13s, and then the 13- to 16-year-olds, and really making sure that you've got the right consent for those children. And the people don't just assume, oh, we can leave them they've seen you before so it's fine now, they're not a new patient. So, we're saying, you've got to make sure that the process of consent is very clear from the beginning. And if someone brings a child, that they're aware what that process is.

Steven Bruce
Okay. What about adoptive parents, Fiona's asked about them?

Sarah Tribe
Well, adoptive parents have taken over the legal responsibility, haven't they? They've taken over the legal parental responsibility.

Steven Bruce
Right. So that's nice and straightforward. Adam has asked whether you have to give every patient this policy that you talked about, the informed consent policy, Sarah.

Sarah Tribe
No, no, no, no, the informed consent policy is purely for the practitioner. So, the patient doesn't have to see that at all. What the patient will see, hopefully, is a patient information leaflet, which gives them all the information, as I've said before, about what's going to happen to them. And then they don't need to read or sign anything else. Because it's up to the practitioner to make sure that they have discussed everything with the patient and got their consent before they do anything. So, it's not a case of them having to read the informed consent policy.

Steven Bruce
Super. I don't like constantly bringing up the Professional Conduct committee, but I suppose in a discussion like this it's not possible to avoid it. Are you aware of situations where a leaflet provided by a practice could be held against the practitioner, in that they've said something which the general councils or the HCPC don't agree with?

Sandra Harding
I haven't seen one in any of the cases that I've read.

Steven Bruce
Okay. Alistair says if we're constantly getting verbal consent, if there's a problem then surely it becomes a he said/she said scenario, which I suppose is what actually happens when you're in front of the professional conduct committee.

Sarah Tribe
Yeah, and it's about their word, what he said, what she said. But when you go before the professional body like that, you are a professional so that comes with some kudos that they will believe that you've done what you said you will have done. So, it's not a case of he said/she said, it's a case of you go and you say look, here's my informed consent policy, I understand what it is, this is what I did, here are my notes. This is how I gain consent. And, Sandra, I think you'll back me up on this, there's something about some professionalism comes into it there.

Sandra Harding
And it is about this, I think it ties in really nicely there as well, dealing with the whole idea of the communication and the words that you've used and the way that you've emphasised and the way that you've explained things. And we were talking to someone from one of the professional bodies and they said if the professional comes across as though they have been professional and they've put all the things in place that we would expect, then we would be looking usually favourable for the professional. Because as you say, he said/she said, those can happen, but what it's about is did you understand what you were doing? Have you got the things in place? Can you provide the evidence? And if so, then we would expect you to be professional and to have done that and so we would believe that you have done it.

Steven Bruce
I guess there aren't many guarantees in professional conduct committee or any other any other hearing, but I think Jonathan Goldring, a barrister who represents osteopaths and chiropractors quite frequently in the committees, he said that the one thing you can be sure of is that if you haven't put it in your notes, then they will assume you did not do it. In terms of consent.

Sandra Harding
Yeah, if it's not documented, it didn't happen. And that's the really important thing and the thing around capacity and things, what you've assessed, make sure you've documented because yeah, if it isn't written down, it didn't happen.

Steven Bruce
More about the grandparents, Kerry has said that she's had cases where the children had been brought in by grandparents for a follow up appointment. The parent has made the appointment and has sent a message about how the child is doing but isn't available at the time to explain the situation. How does that stand in terms of the informed consent for treatment?

Sandra Harding
I think, can I start on that, Sarah? That comes back, Steven, to communication at the beginning. And it's really important if it's a child, that the communication is about how the consent process for that child can happen. Because clearly, if the grandparents have come in, then the mother must be assuming that the grandparents can give consent. So that communication piece hasn't happened because only the people that can give consent for a child are the people that can bring a child to a treatment, even if it's a follow up. Do you want to elaborate, Sarah?

Sarah Tribe
Yeah, that's it. So, it's all about communication right at the start about who needs to be there and who needs to be with the child, but also assessing whether the child is Gillick competent, in which case they can give consent themselves.

Steven Bruce
That could complicate things for a lot of working parents, couldn't it? I wonder how many practitioners will be prepared to make an informed decision themselves about the likelihood of a complaint arising if they treat this 12-year-old, 13-year-old, child, which their parents have previously brought in and which has now been sent in by their parents or their grandparents? I mean, the likelihood of a complaint is extraordinarily low, I'm assuming

Sandra Harding
Normally, yes, completely. You'd hope the level of complaints would be low. But I think what we've always got to remember is it comes back to the conversation we've just had, you know, that he said/she said. If something happens and it's investigated and you haven't got the right people there to give consent. Then the he said/she said is going to go against that professional because they haven't followed the due process that they were meant to be adhering to.

Steven Bruce
Yes. And it's worth bearing in mind, I guess, that lots of practitioner patient relationships which start out well, can easily turn sour if there's an adverse outcome of some sort. So if the child went away and something had gone wrong, at least in the child's opinion, if not, actually then the parent might turn on the practitioner. Ellie says, can you not just tell the patient what you're going to do and then stick an "Is that all right?" on the end? Sarah?

Sarah Tribe
Well, if it's about an ongoing process, it is about saying, as you're going along, "is it okay if I..." so you are saying those words. It's about all the time about, it's what we do anyway, it's what we do as therapists, we talk to our patients, we say, is it okay if you get on the bed? Is it okay if I lift your arm up? You're doing it all the time, so that you're gaining informed consent as you go along.

Steven Bruce
Yes, but earlier on one of your three elements of capacity of consent were that you had to be sure that they had understood all the information and retained it. So just saying "is that okay?" doesn't satisfy that test.

Sarah Tribe
No. So you would on your assessment, when you're assessing or when you're seeing your patient, you will have done an assessment about capacity, you will have done that three-stage test before you've gone any further.

Steven Bruce
Yeah. And having done that assessment for a single inquiry then that's okay, you know, they've got capacity so you don't have to go through all three stages on everything that you get consent for?

Sarah Tribe
No.

Steven Bruce
Right. I've got some very nice comments in here about communication. Aiden says his favourite quote from his mentor at university is "Never miss a good opportunity to shut up." He takes that as a general rule, not just specific to him, which is fair.

Sandra Harding
Matches the ears and mouth, doesn't it? It matches that comment.

Steven Bruce
Fiona says consent is really just common decency and having been in practice for "a number of years" which she puts in inverted commas- don't worry, Fiona, we won't disclose your age- she says she would never dream of doing anything to a patient without discussion and explanation. And you can tell by their eyes and their body language, if they're comfortable before doing anything. And then general chat, she says, as a practitioner, surely, surely, surely, we're ensuring our patients are comfortable and trusting us.

Sandra Harding
Which goes back to the communication piece, doesn't it, where we talked about trust? And I think, thinking about that trust as well, it's also about the words that we use, do we use words that motivate and encourage our patient? Or do we use words that don't? How many times have we heard, and I hold our hands up, we've heard professionals say it, "Your back wears out as you're getting older." That's really not helping and giving a positive outlook. And it's completely different to say that the scan changes, yet they do change, things do change, as you get older, it's like getting grey hair, but it doesn't mean there aren't things that we can still do. And it's that messaging and Deborah uses a nice analogy, where she says, does our communication make our patients with a condition that they're probably going to have for a while, does it make them feel as though they're driving and reconditioned and she has a really nice photograph of a campervan? Or does it make them feel like they're a scrapper, and they're on the scrapheap and they're falling apart. And I think it's this whole piece is so beautifully entwined in the way we communicate, the way we get across, the way we motivate and the whole consent piece, I think is so beautifully wrapped up in the way we deliver that message and the trust and the way that we move forward with that patient and understand them.

Steven Bruce
Kerry, I like this question that she's just sent in, I've not actually thought about this before, but should we document that we have done a test for capacity as well as informed consent?

Sarah Tribe
Yes, yes. That's a very good point. Very good point.

Steven Bruce
Gosh, so maybe we have to have some sort of abbreviation, a three-letter abbreviation for that in our notes somewhere as well, because again, we can't write it out in full, I guess.

Sarah Tribe
Well, the thing is that if you've got your informed consent policy that will cover all your capacity, so therefore if you've got VCO written down that is covered that you know about capacity, and you will have done the capacity test.

Steven Bruce
So, we just put it in the policy and then the VCO means that we've taken that into account. Allister says sorry, what were the three stage tests again, very briefly. Apparently, his son made a noise so he couldn't hear what you said.

Sarah Tribe
Three step test to assess whether somebody has capacity. First of all, you need to make sure that they have understood what you've told them, that they can retain the information and they can weigh up the information to make a decision.

Steven Bruce
So, we've just established in fact that Alistair doesn't have capacity because he couldn't retain the information. Could you just talk me through that as though I'm a patient, I come into your practice, what are you going to say to establish that I have capacity? Obviously, first appearances don't count, because you'd immediately assume I didn't.

Sarah Tribe
I was for a time I was a manager of a care home and this was very much about capacity and whether our residents have capacity or didn't have capacity. And so, if I can just give you a little story about that, because even though you think somebody doesn't have capacity, but they do have capacity. And I'm just thinking about one of our one of our residents who she did have capacity, she'd had a very severe stroke. And her communication was very difficult, but she had capacity. And she loved to sit in the sun. She loved to sunbathe, she loved to sit in the sun, and she didn't want to have any sun cream on at all. And the carers used to be so upset about this because she used to burn. But people with capacity are allowed to make unwise decisions. So, she sat in the sun and she burnt and the carers were really upset about this, but if you've got capacity, you can make unwise decisions. Just because you don't agree with it doesn't mean that they can't do it. So, this was a lady with, as I say, a severe stroke and so you have to really take the time with somebody that you're not sure about, you're not sure whether they have capacity or not, whether they've really understood what you've said to them, ask them to repeat it to you. Ask them to just say it back to you, have they retained what you've said? And then are they able to sort of weigh it up. So, it's a very slow process. And it's not about asking direct questions. It's just about you get a sense as a professional person, take your time to ask them some simple stuff and just repeat it back to you.

Steven Bruce
Right. And so, putting that in the context of a physiotherapy practice, when I come to you, and you've decided you want to stick your elbow into my piriformis, you want to do a grade five manipulation on my upper cervical spine, and you want to do a straight leg raise test. How are you going to make sure I've got the capacity to say yes to all that?

Sarah Tribe
Well, that would have happened right back at the beginning, when I assessed and I would have explained and I would have said, do you know why you're here? Why have you come today? What are you hoping for from today? I would have really, it would be way too late by then. You need to do it right back at the beginning.

Sandra Harding
It's the key piece about listening at the beginning. And that bit that we said when we started today, Steven, that when you listen at the beginning, really making sure you've summarised, you've paraphrased, they've fed it back and you feel they do understand.

Steven Bruce
I'm sorry, I guess the bit I was trying to get at here is twice now you've mentioned they've got to repeat it back to you. Well, that can be a little awkward in a conversation, can't it, if you're talking to an adult of similar nature to us here and you say, right, I've just told you something, can you tell me what I told you? Aren't they gonna feel a little bit cross about that?

Sarah Tribe
You're only going to do this with people that you have a suspicion that they don't have capacity.

Steven Bruce
Thank you, that's helpful. Georgina Taylor, how do you assess capacity? Well, we've just done that, I think. Two questions here about explaining risk. And they're from George and Jen, somebody's moving my questions around, they're asking about whether it's okay to put risks in a particular form of context, would you say the risk of injury from this technique is very low? Or do you have to say, research shows that it's one in 60,000 or 600,000? How specific have you got to be in that?

Sandra Harding
You can determine, I mean, if we use an example, let's go back to what Deborah uses. Because we talked about her earlier and how she uses her risks. In there she does that, she has statistics, so she can quote some of the statistics, so people can make that informed decision. So, she uses that in her script. And I think you can talk about your lived experience. These are the statistics, but this is what I've found. But it's having that conversation that's key. It's making sure people have been made aware, if there are risks, and that they've

been able to say actually, in that case, I don't want to proceed, because that's the bit that will be challenged. Did you explain the risks? Did you give someone the opportunity to say no?

Steven Bruce
Yeah, so I suppose, Sarah, you said earlier on, you said if we're going to do what you physios call grade five manipulations, and what we osteopaths and chiropractors just call manipulations, if you have to say there's a risk of death in this, we can't just say that we have to put that in in a much more specific context. Otherwise, it would terrify the life out of every patient.

Sarah Tribe
You give them statistics, you give them the research, you give them all the figures and the facts and the research behind it. And you can say, and in my experience of however many years I've done a lot of these, I've done this many of these and in my experience, I haven't had any incidents. You can sort of say that, but you need to give them the overall percentages, the research percentages.

Steven Bruce
Jodie's just sent in an observation that he or she is a paramedic as well as an osteopath and that their remit is pretty much as you described, for checking capacity it's whether the patient can understand, retain and then relay information back to you. I'm not surprised that capacity and consent are pretty much the same across all the medical professions, aren't they, because when it goes to court barristers are going to be the same.

Sandra Harding
Yeah, it all came from the same act in the beginning. All the framework started from the same place.

Sarah Tribe
Just talking about that actually, Steven, we haven't talked about written consent. So the osteopath needs written consent for anything that is done intimately. Whereas the physios don't actually, physios need it for anything that's invasive. So, there is a difference there, but you do need to get written consent, so check with your profession, what you need it for and you need to keep a copy in the notes.

Steven Bruce
Yes, and that idea of intimate contact is up for definition, isn't it? Because how close do you have to be to areas that people might regard as intimate for it to require written consent?

Sarah Tribe
They specify, the osteopath code specifies about vaginal or rectal.

Steven Bruce
Now we're talking invasive techniques, surely,

Sarah Tribe
Yeah. But it is an anomaly because we have women's health physios, we have a lot of women's health physios who do a lot of stress incontinence, so but they don't need to have written consent. So different professions.

Steven Bruce
Well, interestingly we had Steven Sandler, who's a very, very well-known osteopath, on the show, we've had him on a number of times, and he does quite a number of PR techniques. And he made the point that actually is not sufficient just to get written consent, they have to also then be given time to consider that. So they have to be given 24 hours to think about it before he can do the treatment. And he has managed to get an exception to that for a patient who was travelling from, I think, Scotland down to his London practice and say, well, they can't travel down, go back and then come back the next day. And I think he cleared that with the general council or whatever. But yeah, it goes beyond just the written document, doesn't it? But a question here, a question from a number of people, is there an informed consent capacity policy template that can be shared, which we've asked, and you've said that you can provide that but it is your business, obviously. And would you suggest that there is no value in a general consent form that the patient signs at the start of the consultation or treatment?

Sarah Tribe
There is nothing legally to stop you doing that, but it wouldn't stand up in court. It's worthless, really. Because all they're consenting to, what are they consenting to? They're signing a piece of paper saying I consent to treatment, but they don't know what the treatment is.

Steven Bruce
I guess, as I said before, I mean, I think that part of the value might be that at least it demonstrates to a court that you are thinking along the right lines, but you couldn't escape what you said earlier, you've still got to put in the notes VCO or your own abbreviation for informed consent, valid consent, being obtained. But you could have a written document that says, these specific techniques carry these risks and you will be told if we think they're appropriate, are you happy to go ahead with treatment? But again, as you said, you still got to get consent at the time. It's worth making the point, though, isn't it? I mean, we talk a lot about written consent, you've mentioned the only times that we require written consent is for those invasive or intimate techniques. Actually, oral consent is fine for virtually everything we do, we just have to record it.

Sandra Harding
So as long as you can evidence it, and as long as if it's challenged, you've gone through the whole process.

Steven Bruce
Lucy says, we established earlier that communication and gaining consent, fully listening and making clear, accurate notes in the room at the time is quite a struggle, especially when a lot of us are also doing all the reception work on top. Any advice?

Sandra Harding
There's no, I'm you'll agree here, it's not easy at the moment when there is so much going on. But I think there's no way we can get around it. It's something we have to do. It's something we have to cover. And I think basically, certainly if I'm honest, it's just slowed a lot of things down, they're taking longer, you're having to spend longer, because there is more that you're having to do right now. But unfortunately, I wouldn't try and take any shortcuts, I think we've probably fully explained why taking the shortcuts is not a good idea.

Sarah Tribe
That's also one of the things that Sandra and I, we do when we when we chat to therapists, it's about again, it's about communication. So, it's explaining to your patients, that part of their treatment is writing up the notes. So, supposing you have 30 minutes, it's 25 minutes treatment, five minutes writing up the notes. So, it's about setting the expectation and so to give you the time, to actually be able to do your notes contemporaneously. And just taking the time to do that and not feeling that you go from one patient to the next patient and the next patient and there is a load of notes to be written up at the end of your session. So, think about that, think about ways that you can try and make your life a little bit a little bit easier and note writing is so important. It's such a such an important part of the treatment, but unless you tell the patient, they can think well I need 30 minutes treatment and then you're going to write up my notes but that isn't the way that we recommend.

Steven Bruce
It is sometimes difficult, of course to get patients out of the room. They think they've paid for half an hour and that's what they're getting. I do remember we did a discussion with Lawrence Butler, who again is a very well established, well known osteopath and he does a lot of medico-legal work, and he said that like you, Sarah, he has his own abbreviation for informed valid consent being obtained. And he said that provided that you can establish that whenever you put that in your notes, this is what you will have said to the patient, maybe it's in your policy, then that's all you have to do. And frankly, writing VCO, or whatever it is, after things is not going to take very long, is it? You've got to write the notes up, that's not going to add much to your time, you just have to think about it as you're working with your patient.

Sandra Harding
Ensuring you've got that process and what is linked to that process. If you're asked to evidence it, can you show it's just part of this whole package of consent.

Steven Bruce
Here's an interesting one from Neil. Neil says, how do you deal with a patient who says, I know there are risks with everything, but I'm not going to relax if we discuss this too much. So please, treatment as you see fit to relieve me of the pain I'm in.

Sarah Tribe
Patients can refuse to be told about the risks, they have that right. So, it's like a doctor, you go to a doctor and say I don't want to know, just do what you need to do. They do have the right to do that. And if that's what they say, then you document that. As long as you document that you're okay.

Steven Bruce
Okay, I wasn't aware of that, that's a nice new piece of information to have. Would you have to document that at the start of every appointment?

Sarah Tribe
Well, I think you need to just be, yes, I think you need to be, I have offered to explain all the risks, benefits, complications of the treatment that I'm about to provide and the patient has declined. Because at the end of the day, if something happened, it's only what's written down. So, the patient could say, well, you never asked me or whatever. But you need to be really sure, so you're saying you don't wish to know this? And again, it's about this, my advice would be that I do tell you these things, but I think it's important that you know, that you can make a decision. However, you can still say that you don't want to know,

Steven Bruce
Actually, you make a point there, which, it comes down to communication, you could express it in such a way as to imply that the patient shouldn't give consent, couldn't you? Look, I'm legally required to do this but do you really want me to go through all this every time I treat you or are you happy just to say that you understand? And that would put them off saying anything else.

Sandra Harding
It goes back to the way we said about how you motivate someone and how you carry that message. But people will decline and have a right to do so as we've said.

Steven Bruce
Here is what I think is a fairly well-established myth in our physical professions: John says is the presence of a patient in front of us not implied consent. They've come for treatment, surely that is consent to treatment.

Sarah Tribe
They have they've appeared in your clinic wanting something from you. Yeah. But all that they've consented to is coming into your clinic, right? But they haven't consented to what you, they may have no idea what you're going to do to them. So, they really do need to be told. There's something about implied consent, if you have your blood pressure taken. So, you start to roll your sleeve up and put your arm out to have your blood pressure taken. That can be implied consent, because you know you're gonna have your blood pressure taken, you know what happens, and that could be implied. But a patient just standing in front of you, they're just standing in front of you because they've consented to come and see you. That's it.

Steven Bruce
Well, I'll tell you what and again, this isn't my subject to discuss. But I went to the Professional Conduct Committee to support an osteopath, who was going through a hearing there. And the complaint against her was that she had not received proper consent to administer ultrasound to a treatment in the foot. Now, most of us would say, well, ultrasound carries no risks with it whatsoever, maybe there are some very, very bizarre circumstances when you might cause risk but ultrasound to a foot, no risks. And she was doing an MSc in ultrasound therapy, so she knew her stuff and she'd said she thought it might work. But the patient successfully took her to the Professional Conduct Committee and was only overturned after a huge amount of distress and having it go to the court of appeal. So you would have thought, wouldn't you, you come in for ultrasound, there isn't much to discuss about that. But on that particular occasion, certainly that patient's presence wasn't enough to imply that he accepted her decision.

Sandra Harding
But I also think that if there are risks, and there are risks, then again, there's your classic example. You've got to discuss them, they've got to be shared and the patient has to be made aware unless they've chosen to decline knowingly.

Steven Bruce
Well, in this case, the argument was not about the risks. It was about the fact that the patient did not feel she had explained the benefits, the likely benefits of treatment and the patient alleged that she didn't have any evidence for the treatment either. So it was, I'm pretty sure it was a vexatious claim by a patient who was just annoyed that she hadn't given him the treatment he had wanted, she'd given what she thought he needed. But again, it was very, very distressing for her and it probably reinforces the need to do everything that you've been discussing so far, if it keeps us out of the Professional Conduct Committee, because it's horrible place to be. Yeah, we've got a quarter of an hour left. I'm told there are masses and masses and masses of questions. So let me just put another few to you. Sam says, what's the difference between intimate and invasive?

Sarah Tribe
So written consent in the world of physiotherapy, you need to get written consent for injection therapy, acupuncture, dry needling, or performing nerve conduction studies. So anything that basically pierces the skin, but it's not a mandatory requirement for an intimate examination.

Steven Bruce
Okay, but surely any PR or PV technique is also invasive?

Sarah Tribe
Yes, and you do need written consent for that in the osteopathic world, but not in the physiotherapy world. Yeah.

Steven Bruce
So, I guess the question there is, well, how do I decide what is what is intimate as opposed to invasive?

Sandra Harding
You'd go to your standard, Steven, and see. Because as you can see, what we're sharing is what one set of standard says isn't quite the same as what another standard says. So, I think you'd have to check yours for the actual definition.

Steven Bruce
Well, it's interesting, there is nothing in the standards which explains that. There must be must be something.

Sarah Tribe
Written consent, if I just tell you this, written consent is only required in law for treatment under sections of the Mental Health Act, Human Fertilisation and Embryology Act and the Human Tissue Act. The Department of Health and subsequently the Chartered Society of Physiotherapy recommended written consent for injection therapy, acupuncture, dry needling and performing nerve conduction studies. So that is what we abide by in our profession.

Steven Bruce
And if somebody doesn't tell me, I will look up whatever the corresponding guidance is, from the General Chiropractic and the General Osteopathic Councils. Rebecca says, she has a patient with mild dementia, short term memory loss and she does seem to have the capacity to make decisions in the moment, but will then forget the decision she's just made. What do you think about that?

Sarah Tribe
Capacity can come and go. It can come and go. So, you do the treatment, when you feel the patient has capacity to consent to that, and then the capacity may go. So, it can come and go.

Sandra Harding
I would make sure in that case with Rebecca, she's very clearly documented that at the time she made the assessment and had the discussion, the patient was deemed to have had the capacity, particularly if someone was to look at the individual later and they didn't have.

Steven Bruce
Okay. Amy says, is it okay to have a policy that all patients below 18 years have a legally responsible adult in the treatment room? I guess the thrust of that is that there might be people who are over the age of 16, who would say I don't want an adult in the room with my treatment, and they have the capacity and the ability to say that.

Sandra Harding
So, I think there, if an individual doesn't want the parent to be there and they've been deemed to be competent than the parent has to be asked to leave the room. So, I think you couldn't put a blanket rule there, because then you'd be overriding the right of the individual who had the capacity to make the decision.

Steven Bruce
But the suggestion from Amy was a legally responsible adult. You could say well, I want a chaperone while I'm treating you.

Sandra Harding
If you want, then we're going down another rabbit warren. If you want to go down the rabbit warren.

Steven Bruce
Oh, we like rabbits.

Sandra Harding
Of chaperones and who can and who can't be a chaperone. Because interestingly, across the professions that we're talking to tonight, physios, osteos and chiropractors, there is a differing opinion in the standards about who can and can't be a chaperone. In physiotherapy, a chaperone has to be someone who has had chaperone training and cannot be a member of the family. Where in osteopathy it's different. So, in physio, if you need a chaperone, either as a therapist or as a patient, it's something that has to be discussed early, is on the patient leaflet, and arranged in advance, which is quite different to how the osteopaths operate.

Steven Bruce
Gosh, I'm staggered that you can't have a chaperone who's a member of the family because that would be presumably somebody's first choice if they were gonna have to get undressed in front of a practitioner.

Sarah Tribe
You could have an informal chaperone who's a member of the family who comes along to undress and things like that. They can accompany the patient, okay, but they can't act as a formal chaperone.

Steven Bruce
Okay. Kerry says she's had many long-term patients who she's obviously discussed the risks with on numerous occasions and when she suggests a technique, they say they know the risks and to get on with it. And I always say, do you remember the risks or shall I go through them with you again? I think from what you were saying earlier, Sarah, actually that's fine. If the patient says I don't want to hear it again, then that's alright.

Sarah Tribe
Yeah, as long as you document it.

Sandra Harding
Document it.

Steven Bruce
Yeah. I haven't read this question, I've just seen the first line from Pip, it says the tongue in cheek side of me wonders when the time will come that a patient complains that we spend so much time assessing capacity, gaining consent and writing notes that they weren't given enough treatment. And genuinely I wonder if your GP is doing all this, there must be about one minute left for actual treatment in their treatment rooms?

Sarah Tribe
Looked like Sandra was gonna say something.

Sandra Harding
Shall I share a question around that? And it is tongue in cheek, Pip, but actually this is a real one. And this is a complaint that came to me when I was looking after a team and comes back down to managing expectations and communication. And you're talking about timings. I had a case where somebody said that 1/10, which was three minutes' worth of their half an hour was not hands on treatment. So please, could they have a 1/10 discount on their bill, because 1/10 of the time wasn't spent treating them. So, you're talking about going down to the minutes and what's happening. I've literally really seen, Steven, that one. So classic example of make sure you get the message across at the beginning about treatment isn't just the hands-on piece, it's the notes and everything. But I saw the individual who wanted their 1/10 of their fee back.

Steven Bruce
Yeah. And then I suspect my reaction would have been well, actually, I don't wanna have an argument about this, you can have your 10% back or whatever it is, but I really don't want to treat you again. And then I'd be accused of failing to provide treatment without good cause or something. Oh, I've got a lovely bit of flattery for you. Somebody says it's lovely to hear that you to understand the differences between osteopaths and chiropractors and the physios' legal rules. And could you also thank, Deborah, who you work with, because it's great to see the professions working together like this. And it genuinely is, isn't it? I've always detested that sort of rivalry or dislike or confrontation between the professions, I don't think it's helpful at all. Julia says, when she's treated by her chiropodist, she has to sign her treatment notes, is that something we should do as chiros or osteo?

Sarah Tribe
There was no legal requirement to do so.

Steven Bruce
I think that's kind of the response to most questions, I think. If you wanted to do it, you could, there's nothing to stop you. Let's face it, you have to make those notes available to patients anyway, if they ask for

them, but there's actually no legal requirement for you to do it. And I'm not actually sure, well, my own experience as an osteopath is that the notes are generally not ready to be signed by the time the patient leaves the treatment room. So, they couldn't do it and they wouldn't understand my handwriting or abbreviations without a lengthy explanation. Georgina says, as an associate in practice, I'm presuming I should have my own informed consent policy, even though I'm working under the umbrella of someone else's company. There's a very interesting question.

Sarah Tribe
Yeah, you go under the company's policy. So, you're working for somebody, and that organisation should have got all their policies in place and given you practising privileges to work there, and you come under their governance. So, you don't need to have a separate informed consent policy. Only if you set up in private practice on your own. But if you're working under an organisation, then you come under their policies.

Steven Bruce
Somebody says, Steven, my patients would definitely not be able to read my handwriting. I wonder who that was, Claire. So, what were we talking about then? Signing the notes? I suppose once again, you could argue that actually you're showing willing by getting patients to sign the notes, it's a demonstration of your intent to communicate with them, isn't it even if it's not legally required, but yeah. Wendy has asked about the FABER test, you mentioned hip abduction earlier on, it puts the patient in an exposed vulnerable position. She always asks if it's okay to do it, but should they sign something for that? Would you consider that an intimate procedure?

Sandra Harding
No, because again, it's part of this whole piece that if you've got your informed consent policy, if you show this is the way you operate, this is the conversation you're having, this is the way you're assessing capacity, then that's fine. You've got your VCO. So, it means that you've been through all the things that you need to go through before you actually carried out that test.

Steven Bruce
Right? Here's an important one on communication for you, Sandra, well, actually, for both of you, ladies. Yasin says, listening to this makes me want to quit, it's an impossible maze to reasonably negotiate and it's a ticking time bomb. So, I think we need to communicate actually, that it isn't as bad as it always seems, when we talk about these legal perils.

Sandra Harding
Absolutely. And I think the thing is there we're giving you scenarios to help you. But actually, if you think about the process we've gone through, what we're seeing is, when the individual steps into your practice or your first have the conversation, you set up your communication, you manage the expectation, they've had information about what's coming so that they know, you don't take them by surprise, and you document it. And if you go through that piece, which most people as Sarah said do go through, the thing that we find

most times is people haven't documented it. And that's often where it falls down. They've had the conversation, they've said, I'm going to be doing this, do you mind this? But they haven't got the policy sorted or it's very old and sitting on the shelf and not being reviewed, or they haven't documented it. I think if you've done those pieces, then it's just, as we said, it's the belt and braces, that's just endorsing what you've been doing. Please don't quit. There is no need to quit around this. Not at all.

Sarah Tribe
No. And everyone loves treating patients and they're there for the patients. And if you think about it, you only need to do your informed consent policy once and all of this paperwork, just do it the once, get it right. Get your foundations, get your kitchen safe, right? Look, you will need to review it but yes, it seems really onerous at the start of it, and you think, oh, my goodness. But once it's there, it's there. And then get on and treat your patients and do what you love.

Sandra Harding
And it becomes a habit. So, you just go through it, you modify your process, because everything's in place, and it becomes a habit and you know you're doing it and you're keeping yourself safe and your patients safe and you can evidence it.

Steven Bruce
There's a lot of interesting questions coming in and I'm tempted to go back to something you were saying there, but I'd rather get through the viewers' questions as best I can in the remaining five minutes. Gary has come up with an interesting situation, if a patient has had to bring an interpreter with them, how can you be assured you have informed consent? And actually, if I can put my spin on that there is a vast difference between a professional interpreter and a member of the family who simply speaks the language because quite often, they will answer for the patient rather than give you the patient's answer.

Sarah Tribe
Absolutely.

Sandra Harding
To give you differences again, in physiotherapy, you can't use a member of the family as an interpreter. Because unless you speak the language you don't know the information they've passed on. So, you actually have to set up an interpreter, either using language line or professionals that we talk to, they may have colleagues or they may talk to a GP surgery who can provide it. But again, it's an area where there is discrepancy between the professions, because family members are allowed to be used by osteopaths.

Steven Bruce
Yes. Okay. Do we have an answer to the question to that? How do we know that we've got informed consent?

Sarah Tribe
If you use an interpreter, who's a trained interpreter, not a member of the family, then you've done everything within your power to make sure that you try and get informed consent. There's nothing more you can do. But you haven't used a family member or as I say, you can in osteopathy, but you just can't in physio, but so you've done your bit, you've done your bit.

Steven Bruce
Okay, but yes, you've done your bit if you've got a trained interpreter, a proper interpreter, but if it isn't one of those, if it's an osteopath and they've brought in someone who's a family member, or even someone who's not a family member, but they're just someone who speaks both languages. Is it enough to say that this went through an interpreter, I asked the right questions, I got the right answers and therefore that's valid consent?

Sandra Harding
You'd have to document that's the process you've been through. And as I say, osteopaths would be allowed to do that, with physiotherapy you wouldn't, you'd have to have the formal trained interpreter.

Steven Bruce
For chiropractors?

Sandra Harding
I can honestly say, I don't know. I'm not sure because I haven't looked up interpretation, but I know with the training we've just done with osteopaths, it's another area where there's a slight difference.

Steven Bruce
Right. Well, I'm astonished you know as much as you do about what osteopaths can do. So we'll let you off not knowing one thing about chiropractors.

Sandra Harding
Is there a chiropractor out there listening, Steven, who can tell us exactly what they're allowed in practice?

Steven Bruce
Well, Alistair has said, I might have to make this the last question, Alistair says, how is it possible to provide adequate info on the risk of treatment when there's no documented statistics or reliable information on these risks? For example, he says, muscle energy technique to supraspinatus or suboccipital inhibition or indeed for example, inhibiting psoas.

Sandra Harding
I think that what we would say is, it depends where you go to get the info from your governing body. So, if I come back and bring Deborah back and her example, she uses statistics that the osteopathic bodies have shared and they're the ones that she uses. So, I think you'd need to be going back and finding out what are

your colleagues, what are your peers using, what are they quoting and where have they got it from? So that's where we would say to go and source it. I've not given him an exact answer. I appreciate that. But Sarah and I cannot churn out for you the statistics of the risks for all of those techniques, obviously.

Steven Bruce
Thank you. I've had lots and lots of compliments coming in for this evening's discussion. I mean, everybody, I think, understands how important it is, even if some people find it a little bit daunting. Fionellis says that tonight has been brilliant, is there a more detailed course we could undertake with you, ladies?

Sandra Harding
Yes. So yes, we have got a website, which Steven will share the info for you. And you can see all the things we offer from policies to templates to training to audits. It's all on there. But we do training around competence and around communication and around consent and around conduct. And we do that with Deborah through Mint Practice and HCPG working together for all this group of professionals. And we do small three-hour sessions on zoom, where we give you your CPD at the end.

Steven Bruce
And if you do a short course on how to type, you could have one of the people who' sending me my questions. I've just realised they put two names together, it's Fiona Ellis, not Fionellis. And I was thinking, is this a Fionnula that's been spelt incorrectly. Fiona, I apologise, I will speak soundly to my team for putting your first name and surname together. We will send out your details, we're going to put your website up on the screen, if it's not there already, so that people can get in touch with you. They can get your newsletter, which will give them your updates on what's going on.

Sarah Tribe
Do sign up for our newsletter, if you go on to our website, you can sign up from there. And then we do it on a monthly basis. We let you know what's going on, any updates in legislation and standards and things that we're running, courses we're running. So yeah, if you sign up for our newsletter, you should be able to get lots of information.

Steven Bruce
Sandra, have you got any, or Sarah, have you anything that you can share with us that I can send out to people after the show, just to show them the sort of thing that you do? I guess they're all looking for a template for informed consent policy. I'm not trying to drive you down that particular route, of course.

Sandra Harding
What we will do is if anyone wants to work with us on things, based on this evening, there's loads of things on the site, go and have a look, we will do a discount for anyone who's been here today, as long as it's booked in April, even if they don't do it in April. So, we will offer a discount for anything anyone wants that's on there. So, whether it be templates, policies, audits, training sessions, we're prepared to offer a discount to tonight's viewers.

Steven Bruce
What I'll do is I will send out a message to everybody who's attended and I will say look, if you press this button, then you will know that they've attended because of this and you'll know to give them their discount. But that has been wonderful. And I do apologise to those people whose questions I haven't had time to ask. But we are one minute overtime already and conscious that people have other things to do in their lives. It's been great fun, and I have absolutely no doubt people are going to say can we get you back again at some stage in the future. So, would that be possible, do you think?

Sandra Harding
Yes.

Sarah Tribe
Yeah.

Steven Bruce
And that's very kind. I only asked that on air because this is recorded and so I have your consent, there are no risks involved, as far as I'm aware, but that'd be brilliant. Thank you so much for this evening.

Sarah Tribe
Thank you very much indeed.

Sandra Harding
Thank you.

Steven Bruce
There was one thing I didn't address that came in from one of the viewers, somebody was saying that as consent and communication is compulsory for osteopaths are all the courses that we can do of equal standard? And of course, you heard from the two ladies that they do run top notch courses in communication and consent amongst other things. There is of course no requirement in the osteopathic act for us to do any courses at all in communication and consent. We simply have to have undertaken at least one activity in it of indeterminate length during the three-year cycle of our CPD and wherever communication and consent is discussed in our broadcasts, you will see it on the certificate afterwards. Which means that when you present them to your peer discussion reviewer at the end of the three years, you'll have loads of stuff which says you have done consent. So, you've got to pay attention. You've got to try and do it and you still have to apply the principles that we discussed this evening. But you don't physically need to attend a course if you haven't the time to do it. That said, how better to learn to understand what is required of you.