Academy of PHYSICAL MEDICINE

Transcript

363R- Consent and Complaints with Chantal Patel and Jonathan Goldring

Steven Bruce

to one. On Location broadcast in four and a half years, we've spent the day trying to recreate our studio here in lecture theatre, one to six at Swansea University. And we have a great studio audience of students, lecturers and local practitioners. Let's hear it for Swansea. Hopefully that came through on the mics. Fabulous. It's really exciting to be here. And I have to say the facilities here are just amazing. I almost wish I was a student again, almost. We're here to talk about consent, complaints and sex with patients. And I threw that last bit and obviously to get your attention, but it's not entirely unreasonable. The most serious complaints or cases often revolve around crossing sexual boundaries. But you can't rule out the possibility surely that you might meet the love of your life across a treatment table. So we'll get some advice on how to handle that a bit later on. I've got two guests this evening. With me in the studio is Chantal Patel, who is the Associate Professor of healthcare law and ethics here at the Swansea University. But I'm also joined via the video link by Jonathan Goldring. Jonathan is a regulatory defence lawyer and is probably li the most experienced Barrister in the country when it comes to defending osteopaths and chiropractors, when complaints reach the Professional Conduct Committee and I love that did that texture behind him that poster I fought the law and I won. He's very, very familiar with the fitness practice practice processes at both the GR SC and the GCC. And he's definitely the champ you want by your side, should you have the misfortune to find yourself in front of either of those committees. So good evening to both of you. Thank you very much for joining us this evening. shontella, you're gonna go first. The first thing that crosses my mind, given the complaints that I hear about that reach the Professional Conduct Committee, do you think we emphasise enough the business of gaining consent properly in practice?

Chantal Patel

I think in in the educational sector, we do emphasise a lot on consent, and the importance of consent. But when one goes into practice, and when one is confronted with the realities of having to see patients and, and obviously, the pressure of having to seek to see patients, when I think that the

process of obtaining consent isn't quite as black and white as we make it in the classroom. So that is problematic in the sense that in the in clinical practice, suddenly you're confronted with patients, different types of patients, and then you're having to think on your feet in order to obtain.

Steven Bruce

So we've got a mixture here of students, staff and practitioners who are long qualified. What is the what is current practice? What do you teach people that they have to do when they're faced with their patient in order to get valid consent or informed consent, which is

Chantal Patel

so so we tend to take it from the legal perspective, in the sense that what the law tells us that we need to do. And so we break it down, in the sense that we say, in order for the consent to be valid, these are the things that you need to be able to be satisfied that the patient, first of all understands the nature of the treatment, that you're going to be proposed that you're proposing that they are of a particular age, and that they have consented, you know that they understand what we're proposing, and also that they've come to the decision to have that particular treatment of their own freewill. And they have to be able to communicate that to you.

Steven Bruce

Well, I suspect, I imagined the people who are students here at the moment, they're probably familiar with the term Gillick competence. A lot of people may not be familiar with that term. Can you explain as you mentioned age a moment ago, so how does that affect us as as chiropractors Gillick

Chantal Patel

competency test really applies for those who are under the age of 16? Because for those age 16 and 17, there are different legislative measures that have been passed as

Steven Bruce

a result of a birth control pill prescription, which I think the underage child parents to know about. Exactly.

Chantal Patel

So So I think the Gillick competency test is quite a narrow competency tests in the sense that it says that if you're of a certain age, under the age of 16, and you fully understand the nature of what is what you're asking, and what is available, then you're permitted to undertake that intervention, without your parents knowledge or without parental knowledge or authority for that matter. But it is really in the context of the child accepting the advice being given by the clinician.

Steven Bruce

One of your colleagues here raised some doubt about the merits or the value of Gillick competence in the context of physical therapy, and suggested that actually, because we are asking people to take off clothes because we're putting hands on their bodies, maybe we couldn't say Gillick competence applied in quite the same way as when you're a doctor prescribing a drug. I don't know Jonathan, have you? Have you come across any areas where Gillick competency has been relevant in the PCCs?

Jonathan Goldring

Sure you record absolutely everything. And that you do your due diligence to make sure that there is a good reason for it. But to be frank, no, I've done hundreds of these earrings and hasn't cropped up once.

Steven Bruce

Right? That's

Chantal Patel

That's reassuring, at least and in the in the clinical health context. That doesn't crop up either. And it's very, very rare that we wouldn't be asking parents to sign the consent Oh, not just to sign the consent form, but also to agree to the interventions that have been proposed or even though legally you don't need it. If the child is really competent, the issue with a good competency test is very much around the fact that it's it's very narrow, it's about the child saying, Yes, I want to have a termination in the face of opposition. Or I want to have a termination without my parents knowing that I'm having that termination.

Steven Bruce

I tell you where this why this arose recently on what I think it was one of our case based discussions is because the issue of gender dysphoria is becoming more evident in society. And we have school teachers who have now been told they have to let parents know if their child has suggested that they want to be known by a different programme or whatever else. And I just envisage that there is a possibility at one point that some young person will come into a clinic and say, Well, this is who I am, this is what I want to be. And I don't want you to tell my parents about this. And I just wonder where we would stand either if we said, Yes, I think you'll Gillick competence. I can go ahead. I don't know your parents advice, or we say, well, actually, I'd prefer not to treat you given that we are required to treat people unless we've got a valid reason. And mustn't we mustn't be we mustn't show any sort of prejudice against a community.

Chantal Patel

I think there are two issues here. And I'm sure Jonathan might want to add to that is the fact that first of all, you know, when you're treating the patient, there is an issue of confidentiality that is between you and the patient. The question that one has to ask as a clinician, is the fact that the child is asking you not to divulge something, is that going to be harmful to the child. So if that's the case, then perhaps you might not want to treat the child because you might want to be considering the potential harm to the child. There isn't a law that says that a child cannot ask, suddenly said certainly at this moment in time, we don't have a law that says that we have to divulge what a child says to us to the parent. Unless, of course, it will have ramifications. So in a school context, when a child says I want to be known by a you know, whatever pronoun etc, that might affect the way in which the teacher is relating to that child. And essentially, that might complicate the situation between the teacher and the child and the teacher's responsibility to have to involve the parents in their educational journey. But when you're treating a patient on a one to one basis, that's a completely different situation. And I'm not sure what we I certainly haven't experienced that in the NHS. So I'm not sure whether that's something that's come up as part and parcel of fitness to practice for osteopath, Jonathan might have more to say about that. But essentially, you should be looking at the patient that you're dealing with, in LightWave, your duty of care towards that particular patient. So if you have a child that has come with the parent, and the parent has agreed for the child to have that particular intervention, then whatever goes on between yourself and the clinician and the patient, that is something that you will need to document in the notes. And you'll have to note the fact that the child is probably saying, I don't want my parents to know X Y, Zed. It's not just about gender dysphoria, that there will be lots of other things that the child might be saying to the clinician, I don't want you to tell my, my family, for example, you know,

Steven Bruce

I've always assumed that, in most cases, for somebody under the age of 60, we will have parental consent, and that that parent will be with the child for every appointment. Obviously, you're you're putting pictures here whether the child will have that consent, first of all, and then we'll come by themselves.

Chantal Patel

And that is very dependent sometimes, I've don't know there are the osteopaths here, they might be able to tell us whether parents insist of being in the room. But sometimes it's not good clinical practice to have the parents intercourse in the in the treating environment, because obviously there will need to be a dialogue between the clinician and and the child. But you could have for example, we've I've had that situation where a child who is pregnant has come for osteopathic treatment, and has told the Osteopath that they don't want the parent to know that they are pregnant. So you're bound by the confidentiality rules here. Of course,

Steven Bruce

of course. Now, I don't know we'll come back to Jonathan on the last topic in a moment. I've just been told that people didn't hear the answer to the first question I put to him. I asked whether Gillick competence had been an issue in any of the professional conduct committees, and Jonathan's

answer basically wasn't it hadn't been an issue so far. But Jonathan, in terms of what we were just talking about gender dysphoria and so on. Any thoughts on that?

Jonathan Goldring

No, I agree. Completely. I think it's important Not to conflate the two issues. When you are treating as a chiropractor or an osteopath, you are looking at capacity in the sense of whether or not the individual has got the capacity for that particular treatment, you're not looking for capacity. In other matters, the fact that somebody might have gender dysphoria, the fact that somebody might be pregnant, the fact that somebody might have a whole range, frankly, of things they don't want their parents to know about may be relevant. But the reality is, what you have to do as a practitioner is look at them and ask yourself, do they understand this intervention that I'm proposing that that's ultimately what needs to be communicated to them? So I, personally, if I had a client that was asking me will have jobs come along, and they've said this to me? Do I have to divulge it? My advice would be in fact, not only do you not divulge it, your duty not to, it's completely irrelevant for the purposes of capacity and gaining capacity in this treatment.

Steven Bruce

austere. And again, it's not strictly a legal question, I suppose. But someone has asked how this affects our insurance. If the parents are not in the room, do we are we insured to carry on treating? So and this is an issue, obviously, of competency and consent?

Chantal Patel

Well, I think it's it all comes back to this to the point of the fact that if the parents have agreed that the child can be treated on their own within that particular room, and they know, the environment, and all of the measures have been taken in order to safeguard the interests of that particular child, then your insurance should cover that, unless, of course, your insurance has made it very clear that they want an adult in that treating room. So that very much depends on the contents of the insurance. contract, we are

Jonathan Goldring

very often I'll just come in on that, because I think that's really important, that doesn't need to be remembered. And most of the practitioners that I come across, they will get the parental consent for the first appointment, report the findings, and thereafter, the child will normally come into the treatment room, at least without the parent and the parent will stay outside. There's an exception to that which I'd advise everyone to try to abide by, if possible. And it's the type of treatment, if there's any type of intimate treatment that's required, if there's any type of downs, disrobing, that sort of thing. Have a parent in the room to make sure. And I'll be speaking about this later. But it but it does crop up a lot of the time. Where there are so I think, I

Steven Bruce

mean, if you're, I guess the problem is most likely to occur with with girls. If they're in shorts and a sports bra top, that's surely fine, because I'd probably wear that on the streets wouldn't.

Jonathan Goldring

It depends what you're doing. Even treating the articles if you're trading around the side of the ribs, got to be careful. And I've had quite a few cases where young teenage girls predominantly have made complaints of sexual nature. This is something that we'll talk about later. But if it is a question of having parent consent and parental presence, if there's any suggestion of intimate treatment, I personally would make sure there's a parent in the room.

Steven Bruce

How does it given that the people emphasised is that consent is an ongoing process, you can't get a patient to sign a form at the beginning of a treatment session, which then is carte blanche for you to do whatever you feel is necessary thereafter. How can how can we say, well, it's okay for a parent to give consent for that child to have treatment once and then not be in the treatment room thereafter.

Chantal Patel

Because at the outset, you have to, you know, as an osteopath, or as a chiropractor, you have to give all of the relevant information to the parent in order for the parent to sign the consent form in the first place. So they should be aware of exactly what it is that you're likely to be doing. But I do agree with Jonathan in the sense that if you're going to be doing treatment, that where the child has to dis, you know, to take all their clothes off or where the nature of the treatment that you're going to be offering is near the intimate parts, then you would be taking those extra steps in order to have someone else in the room whether that's the parent or whether you have a chaperone.

Steven Bruce

Well I like to think that actually if if, if we're treating intimate areas, then we probably offer a chaperone to every patient not just in system one for children.

Chantal Patel

I think I think our problem here is that you know many of the Osteopath and I assume the same with chiropractors that they are sole practitioners and that does present a particular difficulty. There have been two legal cases one where the Osteopath who was treating the children who were playing rugby I think if my memory serves me well and where he was molesting these children, so the whatever he was supposed to be doing It was not in line with osteopathic practice. So this is where you have to be very clear when you're giving the information to the parent that what you're proposing is in line with osteopathic treatment and osteopathic standards. And that probably wouldn't be the same with chiropractic, chiropractic as well. And so in this particular case, the Court did find him guilty of having molested those young boys as a result of what he was doing to them.

But there was another case of where the female patient claimed that she had been touched inappropriately because of the osteopathic treatment that was in the regions of the breast. And the court didn't find him guilty on that, because that was in line with accepted osteopathic treatment.

Steven Bruce

What do you teach people about recording consent? Again, it's an ongoing process. So at the end of my treatment process, I would normally write that I have received valid consent for treatment, I don't write it down for every single different technique that I use. And I don't get written consent from the patient. Because my understanding is that it's really not worth the paper it's written on other than showing good intentions on your part. Well,

Chantal Patel

the fact that you're writing it in the notes in the first place, that in itself was beat the documentation that are all the evidentiary documentation that will be required in a in a court of law. And, you know, the advice that I give when I'm teaching consent, and I don't just do that, here in Swansea University, I do that across the UK. And that I said that you first of all, you have to give, first of all, you have to be satisfied that the patient has got the relevant capacity to be able to make that decision. And the only way that you're going to know that is by giving all of the relevant information, and they have a full understanding of what it is that you're proposing to do. And that is what you need to be writing in your documentation to say that the patient has understood the intervention that is being proposed, this is the information that I have given in order to do XYZ. The difficulty, I think, with this particular discipline, is the fact that you're not working with an actual diagnosis. So you may have differential diagnosis, you may well be having a working diagnosis, for example, which makes it very difficult for you to really clarify what exactly you need to do. Because during treatment, you may have to change. I mean, I don't know, maybe the Osteopath will be able to tell me that. But you may have to change tack depending on what you find when you're examining the patient. And at that point in time, you might have to say to the client or to the patient, that actually, you know, although you're complaining of this, now I have found this, and therefore this is what I'm going to do. And that is what you would need to document I'm

Steven Bruce

not sure I'm allowed to say this is what I'm going to do. I'd have to say, Would you mind if I do this?

Chantal Patel

Whichever way, Jonathan, Jonathan,

Jonathan Goldring

you can gain consent. If you say to a patient, this is what I'm going to do. And the patient says, okay, then all the patient gets onto the couch. You haven't said that. There's I mean, you'll know the case of Montgomery. But there's a there's a paragraph in Montgomery, that that I think sums this point

up nicely, which is that a doctor's duty is not fulfilled by bombarding a patient with technical information, let alone by routinely asking the patient for a signature on a consent form, it really means nothing in its own right, it adds somewhat to the value of the record. But that is not consent. Consent, as Professor has said, it's a process, that the signature at the end of that process might evidence the fact that you've been through the process, it might not. It depends on the patient. It depends on how good you are at communicating. But But again, I always tend to advise my clients, if possible, don't just get the patient to say I consent to the treatment that you've described, also have something in there that adds a little extra that says, everything's been explained to me. I've had an opportunity to ask questions. I've had an opportunity to think about this and I consent, and it's very difficult then when they're being cross examined by the likes of me, in a hearing down the line to say that that didn't happen. Some people say of course, well, I signed it. I didn't read it. But the more you've got in that paragraph at the end, the better.

Steven Bruce

Right. Okay. JJ has sent in a question saying that he or she was always told that they should have a parent present under the age of 16 at all times. What you're saying now is that there may not be a parent present, and what is what age is too young. And as you rightly say that communication is much better sometimes when there isn't that parent Absolutely.

Chantal Patel

Utley think how young how to how young is the person that would be able to come into a treatment room without parental surveillance if you like for want of a better word. I think that's a difficult question to question to answer primarily because I for many of you might remember the, the murder of Jaime Bolger, where prior to that, we had this principle of what we call dually in capac, so that at a particular point in time, so for a 13 year old at that time, you could not consent to anything, because the law was that you didn't have the relevant knowledge for you to be able to consent to something. But as a result of the outrage, you know, the media outrage around the the awful murder of Jamie boldre, in order to persecute John Van Venables and Robert Thompson, they had to get rid of the delay income tax. So actually, we don't have a younger age, it's very much dependent on the ability of that child to be able to understand what is right, and what's wrong. Yes. And so you may have, I don't know whether you remember the genius girl, Ruth Lawrence, who was 13 years old, who went to do a number of degrees, somewhere, you know, you may have her comes along the 10, who does not want the parent to be in the room with her and she fully understands what you're proposing. And so that's it. So you'd have to play it by ear, in essence, you know, when you're dealing when you're dealing with clients. But young,

Steven Bruce

I suppose a bigger problem is when you think I really need to talk to this child without that parent. And you've got to try and get rid of the parent. So you can have that conversation.

Chantal Patel

Absolutely. And and you may have a policy, you may decide that you want to have a policy and you're perfectly entitled to have a policy to say that for every child that you're going to be treating that you want to chaperone in the room or you want to parent in the room. But you know, as part and parcel of what I do in the UK, I do a lot of sessions in the Mary stopes clinic for abortion, for example. Now they have lots of issues with young kids who are coming in for abortion, they are being accompanied by their parents. But they can sense that there's a tension between the parent and the child. And therefore they have to use tactics of how they're going to get that child away from the parent in order for them to be reassured that the child wants to go through with determination. And but that you may have to adopt something like that as well. So it's not as it's, you know, the way in which you deal with your patient is not black and white, you know, you're going to have to think on your feet within that particular context as to whether you can proceed or not.

Steven Bruce

How terrified Do you think the students are when they leave university about the potential for complaints as a result of poor consenting processes? Or procedures or whatever? Maybe we should get them to answer that. Yes.

Chantal Patel

Quite. I mean, from my you know, because I deal with complaints on the NHS, not with the general osteopathic cons. Council. The fact is complaints is a fact of life. Now, when you're providing a service, you know, whether that's in the shops, or whether that's in, you know, at the garage, or whether it's in hospital, it's a fact of life. And so there's something that you have to you're gonna have to deal with, I think, from our perspective, is that as long as you fully understand what you're, you know, what you need to do in order to reassure the likes of Jonathan, that you've done the right thing that you've documented everything, and and that that should stand you in good stead. Yeah.

Steven Bruce

You've talked where you both talked about intimate area treatments and so on. I've just had a question from someone, I don't know the name, who's asked about adults oral treatment. So if we're treating inside the mouth, this person's only been getting oral consent from that for that, should it be written consent for that sort of treatment, I know that if we're doing anything around the genitals, it's certainly internal treatment, we have to get written consent and give people a cooling off period.

Chantal Patel

First of all, the law is only interested in the substance of the agreement between the parties, because they want to know, what have you told this patient? What's the dialogue between you and the patient? So the signature is only one aspect of what you're doing in terms of the of any proposed intervention. You know, oral consent can be just as valid as a written consent. It everything will be dependent on what it is that you've written in your notes, and whether you've written those

contemporaneously. So one of the big problems that we have in the NHS is the notes tends to be written at the end of the day or the end of the week or whenever they want to write those notes. Then the problem with that is that your what you've written may not be an accurate read. flexion of what has happened between you and the patient at the time? So this is why the law places an emphasis on being contemporaneous documentation, because that's the highest, what why would you put something that's not right within your documentation. So if you are having a, an intervention with a patient, you're writing it up right now, and saying, This is what I've done. This is what I've told the patient I'm going to do. This is not what I've done. That in itself is sufficient.

Steven Bruce

We use electronic notes in my clinic, as many many clinics do. And I've always thought one great advantage of that is that once they're signed off, it's clear that they weren't contemporaneous, presumably at the time they were signed off. But it's a perennial problem for my wife who directs the clinic, getting the practitioners to actually sign the bloody notes. Often they leave them open. They've written them, but they've left them open and haven't actually clicked the signature box. I guess that's something that's worth emphasising to people.

You've, you're very timely in your answer there. Sophie sent in a question saying, can we please is one for you, Jonathan, can we please have the most succinct words that are acceptable for consent in our notes? Can it be a tick box? Or do they need to sign something? How do you document consent as you go through on a continuous basis? Are you happy for me to manipulate this? Are you happy for me to soft tissue that is a constant dilemma in the mind of Sophie.

Jonathan Goldring

Consent can be obtained in writing, it can be obtained orally, or it can be obtained through conduct osteopaths and chiropractors, regardless of the way they obtain their consent, have to record the fact that consent have been obtained. So bottom line in a nutshell, you have to record the fact you've got consent. If you're going to do that, if you're going to take the time to write that down in some notes, why not take the time to get the patient to sign it. It to me is astounding the number of cases I get where it for the sake of a few seconds. People don't get those signatures, generally speaking now on intake forms, you'll get them. The words on the form, frankly, do not reflect the consent that's obtained that was on the form, reflect the conversation that you've had with the patient if that conversation wasn't right, if you didn't explain things properly, if you didn't use simple language, if you didn't check that the patient understood, doesn't really matter what you've written on the consent form. So the consent form words are normally quite banal there normally, I've explained, I've explained the treatment, I've explained why this is the these are the benefits, these are the risks, these are the alternatives, I've had an opportunity to ask questions, that's what you normally see on the form, the process of getting consent is far more detailed than that. So I'm afraid there isn't a simple set of words, there will be pro forma forms that you can probably pick up from your various associations that you can copy, but there is no one form that is going to give you unfortunately, the protection that you need, you have to have a conversation with the patient. And it's in terms of

Steven Bruce

in terms of getting ongoing concerns. If like, my clinic, you use electronic notes, there isn't an opportunity at each treatment for the patient to physically sign something.

Jonathan Goldring

Yeah, you don't need that. I mean, it depends on the treatment, the treatment is changing dramatically. For example, let's say that you started doing a bit of lumbar, lower lumbar spinal work, you're doing some hvla treatments, and suddenly, you need to do a coccyx adjustment. You have to really obtain consent. But generally speaking, the consent of the first appointment is rolling. And unless things change dramatically, within the treatment, you don't normally have to get another signature, you can get all consent as things as things progressed. But but there's normally one one signature at the outset, one explanation at the outset. And then if there's a change of circumstances, then you have to reconsider.

Steven Bruce

Right? Well, that's it that's pretty useful and very clear. Because speaking personally, we would go through that process on our intake form of explaining what we're going to do the likely nature of treatment, but during subsequent treatments, when I'm about to manipulate something, I will probably say, so I just like to do this. Is that okay? And that's all I'm gonna say to them. Pros and Cons explained in advance.

Jonathan Goldring

Yeah, that's perfectly normal. You don't have to get them to sign a form. But the point is, once they understand the process, and a lot of osteopaths and chiropractors will repeat similar interventions at each appointment. And it takes time because the treatment is built on each other. So it's perfectly understandable at appointment number one or two to say, look, I'm about to put you into this position. I'm about to put my hands here and bandwidth and that is that again, they say yes. And then on the next appointment, you can just simply say we're going to do the same as last time. So it's not that forensic exercise every single time you touch a patient every single time you do anything you have to go through the same process. Again, there is an there is an implied consent. If you're repeating yourself

Steven Bruce

And that you've probably answered this now because Mark has sent in an observation saying that he read years ago, writing the abbreviation PE T AC, patient examination and treatment degree to with consent in his notes was sufficient. And I also remember we did a one of these broadcasts years ago with Lawrence Butler, who does a lot of medical legal work for osteopath. And he was saying he uses a symbol in his notes, which implies that he's, which suggests that he is asked for consent, and he's got it. And the final thing is that he takes it the same, it's all been agreed to, but it's always the same in every set of notes. So it's always the same abbreviation and it always means the same thing. Is does that give it some validity? Some strength?

Jonathan Goldring

Not really. I mean, I know Lawrence, and he's, he's a very good expert. And I've worked with him in the past, what he's talking about as a gold standard of making sure that you get a tick on every appointment. It's not about the tickets. Not I keep saying it's not about that. It's about the conversation you have. What matters is what's happening at that appointment on that day. The fact that you've written that in your notes means nothing. If the patients come in with subtle numbness and tingling in their legs, and they urinate more frequently, you should be thinking quarter recliner, ask different questions. If you don't do that. You haven't got consent to continue. So there is no, you

Steven Bruce

know, you know, Jonathan, the reality of life is I'm sure you see a lot of this that when an osteopathic chiropractor comes to you probably with their handwritten notes, they've written three almost indecipherable lines for the treatment. And that's it. And then they've had that conversation with the patient. But there's no physical evidence of that when it comes to court four years later. Yeah.

Jonathan Goldring

It's normally the first appointment is to report to findings appointments. And the first appointments that you see detail is the history taking the examination, that process I don't think I've ever seen anywhere in any set of notes. And I've looked at on how many how many pages over the years, but I don't think I've ever seen anyone contemporary contemporaneously say, this is the conversation I had with the patient, I explained x y Zed, I explained that this was the option, this was the benefit. This was the rest of these were the alternatives. And the patient happens, it just doesn't happen like that. So you will get a summary, a brief summary just to simply say, I've explained the risks and the benefits. This is the diagnosis, I understand it or working diagnosis. This is the proposed treatment, I understand it. And I'm happy to go ahead. But you don't necessarily have to spell out exactly what that proposed remedy is, you are expected to put your diagnosis or working diagnosis down there's a sort of process to it. So yeah, it's as long as you go through the motions correctly. And in my view is pretty simple. There were there were sort of four parts to getting consent, the first part is getting the patient's agreement to proceed. And that's whether it be to examination, or possibly treatment, getting the patient to fully understand what's going to happen and why it's going to happen. And explain to the patient what the benefits and the risks are, and alternatives. And the fourth part is capacity, which which you dealt with. But yeah, it's about communication.

Steven Bruce

One thing that struck me in looking through the chiropractic code and the osteopathic practice snap practice standards, is that I thought the ups are a lot more loose than the the chiropractic code, which stipulates if I remember rightly that consent must be documented before treatment. And I inferred from that, that that meant that every time you said to a patient, well, I'd like to do a lumbar adjustment, you had to document it before you could do it, which of course is unreasonable and impractical. And

Jonathan Goldring

that's not the position, the position is that you have to record the fact you've obtained consent. You don't actually have to have a signed consent form. But you have to record the fact you've obtained it. And he says

Steven Bruce

Sarah has just sent in a question, how can you prove what you've said that we hired? You need Jonathan on your side to prove what you've said.

Jonathan Goldring

That's the bottom line, a lot of these cases will come down to one word against another and patients, the number of times I've had patients turn around say, I never understand now. I never got that. I never was told that no, no. It happens all the time. And it's very difficult when you're going back six months, a year, sometimes three or four years to remember the minutiae of a conversation. So the way that most practitioners deal with it is it's a combination of what's in the notes. So is there a record saying that I explained it and the patients signed it and initial day from day to day. And secondly, you've got usual practice. And as a practitioner, you will start to develop a pattern that you go through with every patient and it becomes something that you do day to day. And what we often do as lawyers is we call and get witness statements from those patients and we say this is always explained to me every single appointment, we get practice beat, we get practice managers, and we get that there's ways of proving it. But the easiest and I keep saying the easiest way, or the best thing to do on every occasion is to try to get a paragraph that says, You've told me the diagnosis, you've told me the treatment, you've told me the risks and benefits, I've had a chance to talk to you. Thanks very much. Let's go ahead. And if you've got that, individually signed on each line, that's the safest thing. And it's very hard to dispute that down the line. And the patient, as I said that you will have patients that say, I just signed it, I didn't read it. But generally speaking, if you've got that signature, just to say you explained things it normally enough in a hearing

Steven Bruce

some something from deeds, according to my notes here, previous consent lectures have said that a cop get a copy of the baby's passport, if the father is bringing the baby in is this the case? Now, I can remember we have done discussions ourselves on the fact that only the child's natural parents or those who have been former grants, formerly granted legal guardianship can give consent for a child. But sometimes you kind of make an assumption with the fact that if this child comes in with this adult, and calls him or her dad or mum, then they must be the parent. How can it help? Cautious we got to be about that? How about you found out what

Chantal Patel

the law says, But men will always have parental responsibility because they are the ones who have given birth to the child. So they always have parental rights. So we

Steven Bruce

I don't think I've ever asked a woman bringing a child in Are you the birth mother of this child?

Chantal Patel

But even if it wasn't, you know, the, it depends whether they've been adopted or whatever it is. And so from your perspective, as a practitioner, you'd be asking, you know, they brought the child, so you're making an assumption that that child belongs to that particular person. And but, you know, you would be asking things like, you know, well, you know, date of birth for the child, so they should have a very good knowledge of that baby. But if they are, if they a little bit hesitant, then you might want to be asking more questions. I think when it comes to dads, though, that's a little bit different, because that will be dependent whether they have parental responsibility or not, dads who have been registered on the birth certificate of the child will have automatic parental responsibility. And but of course, the law changed in between, I think, the law change in 2003, if my memory serves me, well, the fact that if you're cohabiting with with someone, and you've had a child together, then you have parental responsibility, provided your name is on the birth certificate. But when if a dad is coming along, then you would need to be asking other questions, because you don't know whether the they're still together. And whether there's been agreement that he brings the child or she brings the child or whatever it is. And at that point in time, if the father says, Yes, I, you know, if you don't have parental responsibility, you have to make an assumption that they that they have, that parental responsibility, just bringing the passport of the child is not going to make a difference one way or another. I don't know what Jonathan thinks

Steven Bruce

if you had a problem like this, Jonathan, where you know, there has been a dispute over the parents rights to give consent.

Jonathan Goldring

I'm not a family lawyer, but I actually have my own parental responsibility and my own child so I've come across it as a father in the past. Having to deal with these issues i To be frank, I don't think you need to start demanding passports. I don't think you need to even frankly start asking people you really the data you will do you really have parental responsibility. As professor says you you'll get an inkling if someone comes in and they don't have the date of birth, they don't know what the address is. Where the child lives, then you start wondering what they're doing there. But are you mama you Dad is enough, frankly, for for the purposes of an FTP no complaints here and I don't think you need to crack that nut with a sledgehammer personally. Yeah,

Steven Bruce

I think I think this observation sent him here by Marisa might be relevant to this. I haven't seen the whole thing. I had a young girl brought in by a lady she was obviously close to leaning on her and tape talking with her throughout. Luckily, as we finished talking, I turned and said, as her mother, I need you to agree. And she blanched and said I'm her ballet teacher. And it turned out that her mother didn't believe there was any issues with her daughter and didn't know that she was with me. Lucky escape but a salutary lesson in not assuming things you believe on natural.

Yeah, and we're assuming that child is under 16. Lisa here so she she's had a 16 year old girl whose parents are also patients and booked the girl in but didn't attend the treatment. On the first occasion. Lisa noticed cut marks on her upper thigh and wasn't sure whether she should inform the parents or not. And then I think we're in a slightly grey area, aren't we because the 16 year old is assumed to have capacity to give consent. Am I right in that? Yes. So therefore we're also by I want to point out duty of confidentiality to the patient again, am I right?

Chantal Patel

Yes. But then there are issues around safeguarding. Yes. So whether whether you whether you whether you think as the practitioner, that there is a safeguarding issue here, so I, I'm making an assumption here that when you're having a conversation with that 16 year old, you'd be asking about the cut marks, you know, Do your parents know, have you, you know, have you been seen by someone else, etc? I think this is something that you should be talking to your parents, would you like me to talk to your parents? So you'd be having that kind of conversation with that, and

Steven Bruce

you might get some cues from

Chantal Patel

something, etc. So if the child was saying, No, I don't want you to tell my parents, but then you would be bound to have to divulge this, whether that's the social services or to whoever's brought the child in the 16 year old, but you'd have to take some kind of actions, you wouldn't just be able to let that run. If in particular, if you think the, you know, whatever is happening to that particular child is an issue of safeguarding. Yes,

Steven Bruce

I don't know any St. Matthews had to go through that process. But that must be a really difficult decision to make. Because effectively, you're going behind the backs of the parent and the child to a third party social services and saying, I think there's something wrong. And if there isn't, you're going to have really upset at least two of your patients.

Chantal Patel

You also you could also use the fact that you might want to say to her, well, I'll write to the to your GP, for example, or to your doctor, and who then might be able to take that up. Or you might want to refer them to casualty to say, Well, I think you need to be seen by someone whether that's the paediatrician or whoever that person might be.

Steven Bruce

Thank you. Well, this is very exciting. We've actually got a question from the audience, which I'm very pleased about. I don't know who it is who's got the question over them? Oh,

Speaker 1

hello. Yeah. My name is Jenny. And I just wanted to ask about the case with the parent, the other parent or second parent, we get a lot of mums like where there's both partners are a mum. And you know, you they come in and, and there'll be like, Yes, I'm the mum. But, yeah, we've had a few cases where it's it. They've they've kind of postulated themselves as the birth mother and but actually, when you drill into it, they're not a legal guardian, but they are cohabiting and they are co parenting.

Steven Bruce

Yeah, and so your question is,

Speaker 1

my question is, how would you approach that? I've had lots of different conversations about it. And we had one tricky situation we've had to actually where the other mum wasn't aware and the other mum was the birth mom. So the baby has been brought in by, you know, the second parent or same sex. same sex couple. Yeah. Both are calling themselves mum. Both a mums. Yeah, but one is the birth mother. Yeah. So I guess this cohabiting is cohabiting not married. Yeah. So we're not in a civil partnership. So just wanted some ideas about how to approach this because it's a kind of common reoccurrence? Yeah, I

Steven Bruce

hadn't anticipated that. But I can see that.

Chantal Patel

I'm trying to work out the scenario. And I'm sure

Speaker 1

this will the mom comes in, and she looks fantastic. Usually,

Chantal Patel

the non birth mum is bringing the child. Yeah. And you're having to deal with a non birth mum in that particular environment? And is that with the consent of the birth mum? So I

Jonathan Goldring

was gonna say, I don't think it changes the situation in the sense that the non birth mom presumably would have parental responsibility for the child, if the non birth mom was on either the birth certificate or there was a court order, or there was some sort of agreement, as I said, I'm not a family lawyer. But are you suggesting that the mom birth mom does not have parental responsibility for the child?

Speaker 1

In some of these cases, they haven't been on the birth certificate. So it's, it becomes quite a complicated conversation, you know? Yeah. So then I guess like, that's what I ended up having to say is, are you on the birth certificate, which you don't really? You know, what? Yeah, it becomes a little bit more.

Jonathan Goldring

I certainly, I would certainly ask the question. I wouldn't necessarily say you're the birth certificate, I would ask the question. Presumably, you have parental responsibility? And if they say yes to that, it's up to you whether you want to challenge that and it's up to you whether you want to take that further and ask more questions and you want to ask them to prove it which can be done. But I wouldn't necessarily ask about the birth certificate because the birth certificate doesn't always tell you the answer. So it is a tricky one. I On. Obviously, if you have one parent that is giving consent, and another parent that isn't, which does happen as well, whether it's same sex parents or not, that's a very difficult situation to be in. And personally, I wouldn't be treating a patient whose parents disagree until that disagreement has been resolved. parental responsibility, you should be able to ask that question. Pretty banali? If it's a non birth parent, okay.

Steven Bruce

Just Does that answer the question? Yeah, yeah,

Speaker 1

that's that makes the car just makes me Yeah, think about the conversation, like a better conversation to have, rather than going straight in with Oh, nice to meet you. Are you on the birth certificate? We just kind of make things a bit one

Steven Bruce

would hope it wouldn't be one would hope it would never be tested in law. Let's hope it never occurs. But at some point, you, you're probably gonna have to say, well, I trusted this person when they said that I do have parental responsibility. And if you've documented a quote, for God's sake, document it put it in writing in very clear English that you did ask, and had no doubts. But yeah, thank you for that. That's an interesting one, which we hadn't considered before. Just on this subject of the 16 year old girl we talked about a moment ago, what happens if a 16 year old says no, I want osteopathic or chiropractic treatment but a parent or both parents say No, I don't think you should have it.

Chantal Patel

The way in which the way in which that has been has been dealt with, as far as the law is concerned, is that when the when the so called gellick competent child or the child who is 60, not quite a team is saying I want to have treatment, you know, the focus is going to be whether the treatment that she is agreeing to or she or he is agreeing to is of benefit to that 16 year old. If the parents are saying no to that, then they can challenge that if they want to. But if in the meantime, you're dealing with that 16 year old and you think that the treatment is beneficial to that 16 year old and the 16 year old does need that particular treatment, you can go ahead and provide that particular treatment whilst the parents can challenge that. I think the issue in terms of 16 year olds becomes more difficult if it was the other way around, in the sense that the parents want her to have the osteopathic treatment, but she doesn't want to have the hospital. So she's refusing the treatment. So then the parents will have a say in terms of whether she can have that treatment. Jonathan?

Jonathan Goldring

Yeah, I wouldn't treat I wouldn't treat a child but there's no giving consent, regardless of the parents views. Frankly, I think that's far too dangerous going going forward. But yeah, I completely agree. I mean, it's a question of capacity. It's a question of Gillick competence, it's a question of assessing the child on the day. Again, from a realistic point of view. I mean, when you're dealing with osteopaths, and chiropractors, you're dealing without any way of being to demean the professions, you're not dealing with life threatening scenarios that require urgent decisions to keep a child alive, necessarily, you might be able to improve the quality of their movement, biomechanics, etc, their life. But But if if you're faced with a situation where you have that triangle of parents and children, and everyone's disagreeing, the safest thing to do is is to go away and sort out between themselves and come back with a case if you from a compliance point of view. I appreciate that doesn't necessarily give the patient the best outcome. But when you're dealing with complementary therapy, I don't personally see there's much merit in taking on that situation unless you really have to. Right. I know that sounds. I know that sounds blunt, and it might sound a little callous, but I look at it from a protection point of view. You're trying to protect your career, you're trying to protect your profession, unless you really have to get involved. Probably don't.

Steven Bruce

I've got a lot of questions here about mechanisms for gaining consent and so on. And we may come back to those but there's one observation here from someone who hasn't given me their name. It

says I'm going before a Professional Conduct Committee PCC, courtesy of the general osteopathic Council in the next couple of months, thanks to a complaint brought brought by a husband and wife team who made the complaint against them. The husband works in insurance and claims and damages and they specialise in suing for damages. And this person says my notes getting consent and what I wrote down have become invaluable. Which kind of leads us nicely Jonathan into the complaints process, your particular area of warfare. Could you just I don't know how many chiropractors we've got in the room here. We've certainly got a lot watching on the virtual stream. Can you talk to us about the the difference in the process between Diorskin G GCC in a sense,

Jonathan Goldring

there's not a huge difference. I mean, I represent, I'd say probably 70% of the chiropractors that have complaints in this country that come before the GCC roughly. It's a very niche market in terms of osteoporosis, less, but I've probably represented over the years 20 or 30 FTP hearings for osteopaths over the years. The major difference between the GR SC and the GCC procedures is that the GS camera filter, and they have a filter in the in the sense that they have screeners at the outset. So when a complaint comes in, it looked at the question is asked, Could that amount to professional misconduct going forward? If the answer to that is no, the complaint can be filtered out of the system and it goes away and the patient's told, the complainants told that's the end of the GCC don't have that. I don't know why they don't have it. They both they both derived their powers under pretty much the same act, it's almost identical. But for whatever reason, the GCC decided not to incorporate that into their process. So it means that if a complaint is made against a chiropractor, the chiropractic counsellor duty bound duty bound to refer it to the investigating committee and off doesn't matter how good it it doesn't matter what what force it is their duty bound to refer it. So in my view, the osteopathic got a slightly more sensible system in place because they have that screening process. That's the major difference between the two. Once you get past the screening process, and the matter goes to the investigating committee, it's almost identical in terms of how things work and whether or not things are going to progress. The rules and the laws are, as I said, almost identical.

Steven Bruce

Probably Probably as the audience's are aware that the investigating committee will decide whether the complaint constitutes something which is covered by the chiropractic code or the osteopathic practice standards and therefore could lead to a finding of some sort. Or if it doesn't, and if it doesn't, then they weren't progressing to the PCC, or the health.

Jonathan Goldring

The test basically so So a patient member, the public says, I don't like the way I was treated on this particular occasion. And then making a complaint to the council, the council will osteopathic side of things, refer it to a screener, who's normally someone with an osteopathic qualification? They'll look at it and they'll make that decision there. And then they might say, yes, there's the potential the test, which we apply, we call it the Galbraith test in law, but the test is whether or not there is a case to answer. What that means is in blunt terms, if you believe everything that being said, Could it amount to unprofessional conduct? So it's it's it's quite a, an easy bar to cross. And that's the test

that's applied both at the investigating committee at G Oscar, the Investigative Committee at the GCC, all they're really asking is, is there a case to answer that could it found proved amount to unacceptable professional misconduct? Thereafter? Sorry? No, no,

Steven Bruce

please carry on.

Jonathan Goldring

I was gonna say if the answer to that is yes, there is a potential case to answer. It then gets referred to the professional conduct committees, each of the various regulators. And the test at the end of that is obviously different, that's based upon evidence is based upon whether or not there is a finding. But the early stages of any complaint will normally pass the threshold, unless it really is a financial matters, for example, don't normally tend to go Go ahead. Or you may have come across that there was a very large complaint by a group called the Good Thinking society. The good thing in society, led by a I think it's Guardian journalist on scene, and they made 600 complaints against chiropractors in in one in one go. Because they didn't have that screening process in place, the chiropractic council had to deal with all 600 complaints. And they had to over the years filter them out and it almost made them go bankrupt. Whereas the general osteopathic counsel when facing similar sorts of things are able to say, well, actually, we don't think there's much merit to this. We're going to put it to one side,

Steven Bruce

for example, but just very briefly, I am going to stand up for the general osteopathic Council and GCC and I don't want to say that it's nothing I would never do as a rule, but you'll probably hear people often saying it, particularly if they've been the victim of a complaint, the subject of a complaint. The gos see the GCC is out to get practitioners. And I think I'm right in saying Jonathan islands, I think based on exactly what you just said that if someone makes a complaint, the gos see, the GCC has no option but to progress that complaint through the stages that Jonathan's described. Now, where I think they do let you down is the gos, see if I'm right says that their target time for resolving a complaint is 50 weeks. And it's gone up again in the end of the last reported quarter to 70 weeks. So that's the average time for resolving a complaint that goes to the Professional Conduct Committee and 70 weeks is a long time in your life, when you can't think of anything else from day to day while you're treating. Is that how you're finding things? Jonathan, there's a huge delay in getting these things resolved.

Jonathan Goldring

Yeah, short answer. And a lot more than that, frankly, in relation to what you said, insofar as they have a duty that the duty of both of these regulators, their overarching duty is to protect the public. And that's a good duty, and it's reasonable duty to have, but that's the way they look at everything. From a legal perspective, once it gets past the investigating committee stage, the cases nine out of 10 times progress. To give you an idea, last year, I think, 2020 to 2023, the JRC had about 40 or 50

complaints that were made to them, the general chiropractic council had about 60, I think complaints made to them. Generally speaking of those complaints that are made, you'll find that about somewhere between eight to 12, we'll get through to a final hearing. And a final hearing is where you have the barristers and all the representation and a final decision. In my experience from the date of the complaint, to that final hearing, it's quite often a year and a half to two years. So what happens is, once the complaint comes in, you have quite a long period of time before it even gets to the investigating committee. So that can quite often take 34567 months. And both of these regulators, although they have target time limits, that doesn't tend to get factored into that part of things. So once they're out taking witness statements instructing experts getting all their evidence together, before they send it to the IC, that can often take, as I said, 678 months, once exactly, I see that thing gets referred. And then it's another normally 10 to 12 months after that, to have a hearing. So yeah, the timescales are a long time I deal with dentists as well, I deal with social workers, I deal with a whole range of of professionals, to be frank dent, this is not that different. So this is this is a problem throughout regulation is not confined just to deals. Sadly, all the GCC,

Steven Bruce

we have, we have quite a few members have a lot of members of the academy. And quite often when when a complaint is made against them, they will come to us and ask what they should do. Our advice is always you know, we're not lawyers, this is what this is what you're bound to do, which is reported to your insurance company, first of all, but we then we tend to keep in touch with them throughout the process and trying to do in our own way, a bit of hand holding. So they've got some support while they're waiting for feedback. But one thing struck me only a I think it was last week someone was saying that the hearing, which is inevitably going to go to the Professional Conduct Committee and it will he will be found guilty of unacceptable professional conduct because he allowed his malpractice insurance to lapse, unwittingly, but it happens and it's not an uncommon thing. But he got a message and email from the GRC saying you're investigating committee hearing has been postponed by a month. And that was the sum total of the communication that he got. And of course he is he's a very, very senior, very experienced osteopath. And he's desperately worried about his career because he doesn't know what we don't know what the outcome will be at the PCC. And for a council which insists on good communication from its members, it seems pretty poor practice that that's how they deal with the registrants. And I know that their focus is on patients, not on registrants but nonetheless couldn't improve. We should point out Jonathan, you've worked at the GRC originally, didn't you and at some time ago,

Jonathan Goldring

such as a legal assessor which is sort of an independent role and still independent barrister advising their committees as to the legal side of things. So no, I never hoped for the GIC. But I was a legal assessor on that committee for a while. The short answer is could they improve? Yes, of course they could improve. There's a lot that all of these regulators could do to improve. It's an extremely frustrating, harrowing experience. My I like you, I know my clients, I meet my clients for months, if not years, and I deal with them and it's It's devastating to have this hanging over you that professional reputation. People, I've sadly had clients commit suicide with these matters outstanding. It shouldn't be underestimated, it impacts in every corner of your life, it can impact on the reputation, you can impact on business, your family, and it does hang over until it's until it's done. And, you know, I've had grown sort of 22 stones, six foot six rugby players break down into

tears at the end of a case when it's finally over because of the relief of just being over. So I never underestimate that you can't unfortunately, make that will turn faster. You can object when they say that they want to postpone the hearing to get different types of evidence and you can make the representations but the initial stages and how long it takes to go through the initial stages of the complaint to the IC to the PCC there's very little we, as lawyers, frankly, can do to make that process quicker. It's the membership that needs to have that voice to be frank. It's the registrants that are paying every year for their counsel, to protect the public and to protect their interests. They're the ones that need to make their voice known. And that can only really be done through the council. Do

Steven Bruce

you actually think that the general councils have got too much of a leaning towards patient safety and not enough towards looking after the well being of the registrant? Their

Jonathan Goldring

overarching objective is to public? So the short answer again is yes, they are but but that is their role. I mean, they are there, ultimately to protect the public. Some Australian and kiwi councils, they have a different motto, they're there to protect the profession. But but in this country that councils are very much leaning towards patient each patient centric and Dan is the way it is. I don't think they can be criticised for that. That's their job.

Steven Bruce

So of course, the general osteopathic Council actively they took out of the act their role, their role in promoting the professional some years ago, didn't they? Because they saw it as being their priority to protect the public. I want to put some colour on what Jonathan was saying there about how it affects the registrants. And Jonathan is very familiar with this particular case, because it's actually I think it's now been written into case law for lots of lawyers to study. But I spoke to the registrant the Osteopath concerned only, me last week, actually. And she had carried out treatment on a patient and I think it was ultrasound treatment to an ankle, it's fairly, fairly uncontroversial treatments, and she was conducting an MSc and ultrasound at the time. And the patient subsequently decided to complain about it. And there are other things that have gone on as well here. I think there were some issues of patient misbehaviour. But leaving that aside, this went to the Professional Conduct Committee it took I think, I don't know it took a long time, Jonathan will may well remember the the length of time it took. But the council found against her and imposed conditions of practice, which she was quite devastated about, as she was in tears at the end of pretty much every hearing, as far as I recall. And so then went to the court of appeals and my licencing, the Supreme Court to Jonathan, the who's

Jonathan Goldring

the lawyer, the GAO, I

Steven Bruce

know you weren't but you know, of the case. I know, because we mentioned it after the Supreme Court eventually. But anyway, and you know, a Far be it from me ever to say anything nice about lawyers, but saying sorry, Jonathan, but the the finding that was handed down by the judge in the court of appeal was a model of clear English, and effectively told the general osteopathic counsel they've mishandled the hearing. And that because of that, if the case had to be the conviction had to be dismissed. And I think it said words to the effect of you're welcome to take this back to a new Professional Conduct Committee, if you like. But the implication was very clear that you'd be idiots to do that, and they didn't. Now that process took about two years and that poor woman, I mean, it's extraordinary the stress that poor woman went through, I mean, she was in tears every time I saw her at the general osteopathic Council, but I didn't follow it up after I feel very bad about this, because I said I was going to keep in touch with her. But I just got the sense that he wanted to keep it at a distance over this. When I spoke to her last week, she said that shortly after that she had suffered an epileptic seizure. And the neurologist said it was almost certainly due to the stress of the proceedings she'd been through. And for four years, she couldn't drive a car, which meant she couldn't get to work. And now I assume the stress is over at the hearing. And then I think, well, there's another four years, this poor woman has had to go through it, and she's still very, very stressed about the whole thing. And I think he may be an exception, but nonetheless,

Jonathan Goldring

I don't think so you as you know, you asked me to reach out to see if I could find some clients to come and speak today about their experience, and I did and I contacted a number of people. They don't want to because they want to put it behind them because they They are still suffering that the stress and the drama of these hearings, they don't want to drag them up again. So, yeah, I've never underestimated the effect. And

Steven Bruce

these are people again, who have had no case to answer.

Jonathan Goldring

At the end, you get a lot of people deregistering. Now as well that have been through this process, I've got quite a few clients that have been through it and said, Never again. And I'd rather call myself and osteologist than carry on. So yeah, it's it's huge. It's, there's a really, really high impact. And that shouldn't be underestimated. And if you are there as an association to help people through that, that makes a huge difference as well. Because I know a lot of people don't have that support. And

Steven Bruce

well, it's a very lonely profession, isn't it? And people find themselves waiting for communication waiting for information, and it's just not there. Yeah. So Jonathan, assuming, statistically, I suppose, very few people are likely to be the victim of a complaint or subject of a complaint, what is the best

process they can go through to minimise the time that it's going to take to get to a conclusion and to minimise the damage to themselves?

Jonathan Goldring

To pass the time, nothing really you can do for that, as I keep saying the time is dictated to by the council's and by the regulators that decide whether they have a committee free to hear and deal with the case. So you can't do much about that side of things. Unfortunately, we're stuck with that at the moment. If you want to mitigate, obviously, the damage to yourself, then you've got to have a good legal team on board and bound to say that. But that's the reality you need people involved early. You say you get contacted by members asking you questions when a complaint is made, like quite often pick up the pieces of early advice. That hasn't been correct. So I think I gave an example earlier of calling recliner, and spotting the symptoms of called a recliner. So I've had a few cases in the past where that sort of thing has cropped up, a complaint is made and both gr scan the GCC give you 28 days to respond. So when the patient when the formal notification of complaint is given, they say you've got 20 days to respond and people panic and they think, oh my God, I've got to write something down, I've got to get something out, I've got to say something. And at that stage, a lot of the evidence hasn't been gathered, you don't have the benefit of your own expert, you don't have quite a few witness statements that you might be wanting. And people do a knee jerk reaction response. And they might say something like, oh, well, they didn't have subtle numbness. So I assumed everything was okay. And that's the end of it. The fact that they've admitted the other types of symptoms that you might expect with coding, such as your tingling or your urination and that sort of thing. The fact they didn't mention that, we'll come back to bite them a year later, because there'll be cross examined, we've mentioned so long as when you mentioned the other thing, well, is it because maybe you didn't know what the symptoms were? And so that initial response, that initial reaction has to be watertight. And I I advise different stages of proceedings. But the advice I'd give is, if you want things don't go well. Get help early on very early on. Don't assume that you have to wait until the final here because everything you say everything you write down every email you send, will count. So there are there are things you can do to mitigate it. You can't make it faster, I'm afraid.

Steven Bruce

No. But when they get that, that notice that they've got to respond within 28 days, they do need some legal eyes over whatever it is they want to say.

Jonathan Goldring

Yeah, and sadly, a lot of people don't get that. A lot of the insurance companies don't cover those initial stages, or they do cover it, but but to a very limited extent five 600 pounds, some people have to turn to their associations. The general rule is if you don't have a lawyer to help you at that stage, say nothing would be my advice. The the exception to that rule is, you know, obviously, if a patient says I was treated on the 24th of December, and you've got proof that you were out of the country on holiday in Spain, and of course sent send your travel certificates in and say, it wasn't me, but generally speaking, if there is going to be a likely case to answer so in other words, if there is some

evidence that that is going to go forward, what's the point of knowing the colours to the mast early on, before you've got all the facts? And time and time again, it comes back to bite people.

Steven Bruce

Okay, Jonathan, I did promise people we talked about having sex with patients as well. I did warn them in the last broadcast. There was no practical demonstration this evening. But nonetheless, you and I discussed the fact that I wanted to talk about this when we met the other day. That there is always the possibility you want to build a relationship with a patient who you meet through clinical practice, or the fact that you're treating someone He's already a friend, what are the rules? What are the guidelines? How does it go in a court of law, or

Jonathan Goldring

first is no possibility handled a lot. And this isn't just for chiropractors, I'm afraid this stretches across many professions. But I have an abnormal as well, osteoporosis as well forgive me, I have an abnormally high number of what I call sex cases, sexual misconduct cases where there is a patient practitioner relationship. And that just I don't know why. But it's it is a high number. If you look at again at GEOSS. Last year, out of the, you know, I think they had 13, professional conduct professional committee conduct decisions, I think four of them were six cases. So it does happen a lot. What are the rules? Well, the rules are very simple, don't have a relationship with a patient end off. If you are attracted to a patient, discuss it with your colleagues, discuss it with any mentors or any legal advisors that you might have, and say that this has happened. Don't discuss it with the patient, definitely don't act on it. And if at the end of that discussion, you feel that you can't carry on treating that patient, because of your feelings towards them, you actually have a duty to stop treating them. But also to make sure that you don't make them free, and it's their fault. So you have to find them another practitioner, you have to make sure that there's that they're still looked after. But if you are found having any type of sexual relationship with a patient, whether it's full sex or whether it's going out for for dinner, and having a cosy chat in front of a fire and a coffee, you are going to be in trouble with your regulator. And it's considered probably one of the most serious breaches of the codes, people get struck off for left, right and centre. So in terms of current patients don't have relationships with them. It's that simple. If you think he said at the outset, you can't help yourself, there are some people that might fall in love with a patient. Well, that does happen. And I know some practitioners that are married to people that are their former patients, but you have to do it in the right order. The general rules are, if you see that happening, stop treating them. The next question is, can you have a relationship with a former patient? And there are guidelines and there are rules about that. And again, any lawyer worth their salt will say well, don't unless you really, really, really have to, because that's going to come back to bite you. But you have to then start asking yourself a whole series of questions. There's, there's clearly a power imbalance between any practitioner and a patient, there's always going to be a power imbalance. And you have to ask if this relationship get off the ground because of that power imbalance? Did I use my power to manipulate that relationship? What details do I know about this person as a patient? How long did I treat them as a patient for there's a whole series of things that you have to think about. And if you want to look at the guidance, the PSA, or the old care, regulate regulators, they've issued guidance, gr SC and the GCC have issued their own guidance on sexual boundaries with patients. And it's pretty clear that everything is steered towards avoidance. But if you really do find yourself in that position where you can't help it, because that relationship has blossomed and it's come out of nowhere, stop treating

them professionally. And really think hard and speak to colleagues about whether or not it's appropriate to continue seeing them even when they are no longer a patient and document those discussions document the fact that you've thought about it. Because you're the onus will be on you later to prove that you've gone through the motions.

Steven Bruce

When we spoke in London, you actually I think recommended that you might actually say to the patient, I'm going to have to stop treating you because putting it bluntly, I fancy you. And that is a probably a better chance at wine than most of us have had in our lives. And I might work on that one. But I mean, is that worth having? Is that having that discussion with the patient at that point, because you still have power imbalance? Yeah,

Jonathan Goldring

you don't really have that conversation. If it's a mutual attraction and the patient's flirting with you and you're flirting with them, then you've already crossed the line. Frankly, you've already infant providing personal information about your life is considered potentially a breach of professional and sexual boundaries. So you shouldn't get to that stage. If there's something that you think is developing, then you effectively need to just stop treating the patient you don't have to I don't think it's necessarily a good idea to say to the patient, it's because I fancy always because there's certainly other you can simply say, for professional reasons. I can't carry on treating you anymore, but I found you my colleague next door and other place around the corner. You don't want the patient to feel like it's their fault ever. And that's really important. So again, it's fact specific. It depends on the circumstances. But again, I would, it's one of those areas that the onus shifts to you. And if you find yourself as a practitioner in that scenario, you're going to be the one that has to prove that you did everything right, rather than the other way around, which is the way we normally do law. Yeah,

Steven Bruce

and you've opened perhaps a can of worms there, because you said, you shouldn't even be sharing anything personal about yourself, which I suspect that most of us do, regardless of whether we've got an attraction to our patients.

Jonathan Goldring

Again, it depends, but they're the sorts of things that they list in that guidance as examples of sexualized behaviour. Sharing information about yourself is simply one of those. So when it comes to a hearing, and I'm representing you, and the patient says something along the lines of well, I know he's got an eight bedroom house in the Cotswolds and a villa in the south of Spain, it sort of makes you worry about osteopaths,

Steven Bruce

here, not lawyers.

Jonathan Goldring

Makes you it makes you wonder how they got that information. And it's because the information was was shared. So, again, it is difficult because you do develop friendships with patients over the years and you're not a robot at the end of the day, you've got to have some degree of humanity. But just don't give away too much information about yourself, keep it professional, keep it divided.

Steven Bruce

Right? What about them? Someone who's a friend before you start treating?

Jonathan Goldring

Again, there's no difference between a friend and a patient, you have to treat every everyone the same. So it makes no difference. And you have to take notes on a lot of people that treat their friends and don't don't make notes. Don't put them on their books they should. So yeah, there's no distinction now, I'm afraid. Well, I

Steven Bruce

imagine that's something that you emphasise the whole time, isn't it, it's got to go in the notes. And, and the closer you sail to the wind, if that's the right expression, I suspect the more important it is that you make more copious notes that the appointment was conducted. Now we've got a couple of couple of points have been brought in here, Jonathan, and I suspect that they represent what I said about that. Maybe a slight misconception about how the general counsel's work. And apologies to Steven Terry, if I've got this wrong, but Steve says about the couple that complained about him, the one that he said made a business of complaining. He said the screeners and the investigative Investigative Committee believe these scammers lies, no common sense was applied. Now, I'm not sure we can come back to in just a second. So I'm not sure whether the common sense is what they have to apply, they just have to assign it to

Jonathan Goldring

me, they're not making decisions. So the screen and the investigating committee are not find as a fact that that's not their role. They are trying to win the test again. And basically what you have to do is you have to look at the paperwork, you have to look at the documents. And you have to ask the legal test is this taken at its highest? Is this case capable of a finding of professional misconduct? What taken at its highest means is in lay terms, if you believe what they're saying is true. That doesn't mean that the committee actually believe what they're saying is true, it doesn't mean that they've accepted their account, it simply means that there is a case that should go forward. The ultimate arbiters of fact, of course, are the Professional Conduct Committee, and he will have his opportunity in due course to argue his case with them. But the investigating committee and the screeners they're not interested, frankly, in a he said she said argument they're interested in, is there some evidence that can go forward? Now, if if there are inherent inconsistencies within the

evidence on its it within itself, if there are obvious flaws within it, that have got nothing to do with your particular version of events? So for example, if if husband says it happened on the 19th of January and wife said it happened in February, on their evidence alone, there's an inconsistency, you can draw that to the attention of the committee and say, but there's potentially an issue here. And the committee's are allowed to look at the weight and the nature of the evidence, but what they're not allowed to do is fact find, so I wouldn't be too disheartened by the fact you've got past the screeners in the investigating committee that's fairly normal. He'll have his day he'll have his chance to argue his case, hopefully.

Steven Bruce

I'm very pleased that the case against me never got past the investigating committee, but that's a different different story. Perhaps. Terry's you mentioned the PSA and another agency earlier on. But Terry here says that he made vocal complaints about the processes it was clearly unfair and hamfisted. And he wrote this down, made his feelings known and said that no one oversees the regulators and then was immediately asked to submit all his CBD evidence the next month, which he thinks is a rather unlikely coincidence. But the point I'm making here is that there is an agency that I precedes the regulators, which is the PSA in the, in the case of GCC and grsc. Are they effective? Yeah,

Jonathan Goldring

I mean, they, the PSA, provide annual reports on almost all healthcare regulators. So, they are the people that the GCC and GRC are most afraid of. They're the people that look at the timelines, they're the people that look at the way they do their business. Unfortunately, we don't all rather the public don't have a direct line of communication with the PSA. Although there is nothing to stop individuals from trying to make their views known if they want to, but yes, there is a regulator of regulators that is the PSA and you will find if you go online and type in G, Oscar PSA, you'll find all of their reports online and their criticisms of these organisations and also their, their praise each year. And timescales are one of the biggest, biggest issues that they raise every year. Unfortunately, you know, it's not improving but but it is something that the PSA criticise, so

Steven Bruce

can, for example, registrants make a direct approach to the PSA and say, I don't think my council is working effectively.

Jonathan Goldring

You can try you're not likely to get a set of ears, it's gonna listen to be frank, you're better doing it through an association. You're better doing it with a large voice. So there are stakeholders that the PSA listen to. So you're better off having a large group of you, for example, your association or some of the other chiropractic. Osteopathic Association is doing it. And they do do that. And as I said, it's at the moment, not really working.

Steven Bruce

Sadly, this is an interesting question from Chris here. Who are Christopher, who you're what you've described as the the process that gets you to the PCC, which is entirely cost and risk free for the complainant. Now, Chris has said Does it actually does being deregistered actually make you any safer from legal action?

Jonathan Goldring

civil legal action? No. And your previous question, the chat that said that the husband and wife team are both in claims and insurance. It doesn't surprise me. People often use the regulator as a as a freebie, as a freebie is a dry run, to try to get the result they want before pursuing a civil claim. And if you go to a civil lawyer, personal injury lawyers say I've been hurt by x y Zed. They quite often say we'll make a complaint first and the regulator because it's free, the regulator will pay for the expert, the regulator will do all of that. And at the end of the day, there is a finding that that you've done something wrong that counts heavily in their favour when it comes to settling the claim. So yeah, unfortunately, it's not uncommon. Being deregistered is not going to prevent necessarily somebody from making a civil claim against you. But it will certainly stop you going through the I'm not advocating being deregistered. But it will certainly stop you from having to face your own regulator.

Steven Bruce

Yeah, I suppose we're all familiar with the concept that you can't be tried twice for the same crime. But this isn't quite the same thing as if you're sorry. Yeah.

Jonathan Goldring

I mean, I have clients that go through the criminal process and get acquitted. And then they go through the regulatory process and get acquitted. And then they go through the civil process, and they have to pay huge sums of money or insurance do. So no, it's not unusual to be charged two or three times but by different jurisdictions,

Chantal Patel

and the civil legal process is not stress free. If we were trying to avoid that, then that wouldn't be the case, because it's as stressful as going through the reg. Reg,

Steven Bruce

I guess in answer to I think it was it Christopher's question from from a practitioners point of view, it is slightly more difficult for the patient to complain about you through the civil courts are more expensive, at least than it is to go through the general counsel's because it

Jonathan Goldring

costs the cost of patient nothing to go through the gym. Well, that's the whole point. So they get they get all of the benefits, effectively, of a dry run. But it can go the other way. If you've got a good lawyer on board that gets you a quick cheat, it can work in your favour. So you know, sometimes it can stop a civil case.

Steven Bruce

Yes. Yeah. I did have a question here. A moment ago. Someone's been invited. Sara says, she has been invited to the wedding of a couple of patients. And she says now I presume she has to say no.

Jonathan Goldring

It's slightly different. You've got professional boundaries, you got sexual boundaries. If you want a lawyer's answer, it probably is don't go keep them separate. They're your patients. In reality, we We all know that that doesn't happen in the real world. And as long as you are not treating them any differently, and as long as you're not divulging personal information, and you're not using it to any advantage, then it's probably okay to have friends who are also patients, and I know people do in reality. But the problem you get is if a complaint comes in later, and if a complaint comes in later, and those friends turn against you, and I've seen that hundreds of times, the fact that you've crossed those professional boundaries previously, can come back to haunt you. So if you want to leave a squeaky clean life, keep your business and your private life separate. And you're going to reduce the noise, you're going to reduce the complaints.

Steven Bruce

Yeah. Krista have a different Christopher's since there is the same Christopher sorry, sent in a question about whether if we all end up under the HCPC? Are things any different?

Jonathan Goldring

Yeah, we don't. We don't know if that's gonna happen. I work at the NCPC as well. To be honest, I doubt it. I genuinely think that the chiropractic and the osteopathic councils compared to some of the others that I deal with are actually fairer. And I know you're not necessarily gonna like that answer. And I'm a defence Africa, I, you know, my job is to defend, not to prosecute, but but in my experience, they are actually they're actually pretty reasonable, making sure that you have a fair hearing. If you go to the NMC, you go to the GDC, you go to the GMC, they've got 10s of 1000s of cases, in a backlog, it's it's much, much quicker, you don't get the same checks and balances, because they've got such a small number of cases each year. And because I've got quite a reasonable amount of committee members, you do get a fair hearing in my experience. And you know, one of the you can see that if you look at the results, because about 90% of cases are thrown out.

Steven Bruce

We're not suddenly over 90% of your cases are found no case. Yeah,

Jonathan Goldring

yeah. But if you look, if you look at actually their statistics on their FTP reports, you will see a lot of them actually don't get don't get, don't result in conditions of practice or suspension, you get an acknowledgment or no findings at all, so, so I wouldn't be too dismissive at the moment, I would prefer them to stay out of the HCPC myself, because I think once you get swallowed by that larger organisation, those checks and balances go.

Steven Bruce

Jonathan, thank you very much for giving up your time this evening. I appreciate it's a bit later for you over there in France than it is here. But with all your experience of these cases and your familiarity with not just the process, but the people involved in the BCCs. I mean, it is, I don't know if the water is any less muddy for the people watching and in the room here, but it certainly added to their knowledge. And Chantel thank you as well for giving up your time to come in and talk to us. Well, I'm sorry, we have to end the live broadcast there. But I do hope you found that useful. And I really hope that you never find yourself on the wrong end of a complaint. That's it from us here in Swansea. Good night.