Academy of PHYSICAL MEDICINE

Transcript

Consent
With Paul Grant and Jo Redman

APM: good evening. Welcome once again to the Academy of physical medicine. A great pleasure that you can join us in the week before Christmas, this is of course our last broadcast of the year and I think we've actually got a very special lineup of guests this evening and a very important topic to cover so I hope you're gonna enjoy it is ninety minutes of CPD as always, ninety minutes of learning with others for the UK osteopaths and chiropractors and I know you're going to get an enormous amount from this evening's discussion. I said, my guests are special I have two very distinguished guests joining me this evening. I have, first of all, Paul Grant now Paul is a senior partner at BSG solicitors based in London and he is not only a solicitor, but he's also been an osteopath for something like thirty years prior to which he was working with his father, also an osteopath and had learned and was practicing techniques of osteopathy, but this of course was in the days before we had a general counsel to regulate how we did things.

APM: More of that later when we discuss the law, Urm Paul now works for Bailyn's as their specialist, solicitor when it comes to defending cases both for osteopaths and Chiropractors, and I've challenged him on this a few minutes ago and he shows me that he has a very good track record of success, um, in defending people when they are faced with complaints and they're up against the disciplinary committees or legal action. So that's my first guest. My second guest is actually a patient from my own clinic, Jo Redmoan. Now Jo is a particular interest to us this evening because we discussing communications and consent. Um, Jo was diagnosed with aspergers at the age of twenty three, so quite late on. And as a result of that, in the ensuing conversations in the clinic, um, I became aware of her involvement in making the difficulties of aspergers and autism known to a wider audience. I mean, that's, so, she's quite remarkable because she speaks to quite large audiences on a regular basis and how to deal with the problems of those conditions.

APM: Urm not only is she remarkable in that sense she's also a three times world champion kickboxer and as a patient in my own clinic, I'm hoping that she's going to give you the down and dirty on exactly what we got right and

probably wrong in my own clinic when she visited us several years ago, for the first time urm, I'm hoping she'll pull no punches, which is perhaps not wishful thinking with a kickboxer on. Welcome Paul. Welcome. Jo. Paul let's Start with you. Um, as I mentioned earlier on you've been a solicitor for forty years, I think haven't you.

Paul: Fourty-Four years in fact

APM: for fourty-four years. And you've spent a lot of time in the world of osteopathy, not least because your father and your son is an osteopath, your sister is an osteopath, your niece is an osteopaths, so you know our world very, very well, but of course you know the other side of our world as well. That is when people unfortunately faced some sort of criticism, ended up in front of disciplinarians. What is it that gets people into that sort of trouble? Most commonly?

Paul: It's interesting you should say that because the latest magazine Osteopathy today, they're actually encapsulated exactly what are the problems, the main problems are, communication and consent, and then you go down the ladder. You go to clinical matters. You talk about various other factors that come into it, but the main is communication because they do get a suitcase here, criminal cases, but the main communication and consent is how to -

APM: We lumb those two things together don't we communication. Is is connected to consent, but it's not the same thing. Do you get people do you have to defend people because their communications are poor or is it always a question of informed consent that gets them into trouble?

Paul: Not only informed consent. For instance, I have a case at the moment I can't obviously cannot give you any details. That's coming out to the end of January where a case where the patient comes to a clinic twice and he's very informed as to what his condition is and has been to other osteopaths. That patient has claimed that my client said rather offensive matters to him and did not diagnose him properly. Now my clients notes are extremely good and very able and she's a good communicator. Who's who of the committee to decide between. So it's either something going on in the communication or somebody is not telling the truth or non consent, non consent issue breakdown in communication.

APM: How does this, how can you realistically revolt, resolve this in a court because there are only two people in the room and we may be relying on these days on electronic notes, which is difficult to I imagine ammend after the event because it will be electronically tagged when they were made up, but let's face it, lots of practitioners will write up their notes either at the end of the day or whenever it might be. They wouldn't necessarily do them immediately say when it comes up is how do you prove that your client is telling the truth that communicated correctly or the plaintiff is correct in saying that they didn't

Paul: Well I'm giving away some tricks now of the trade, but obviously usually and indeed looking at this as the paradigm, the cases coming up, the expert they

use rightly, and you said, I can't say the notes are wrong. In other words that if you've got the note said, generally I haven't known a case I knew about one case ever. Have they ever challenge the PCC professional conduct committee who do the hearing. Wherever they actually challenged the actual person, say the eighth notes aren't accurate aren't properly put together. The generally they accept those are contemporaneous notes. I mean there's some issues that I can tell you about making notes

APM: Yeah please, well I was about to go down that route

Paul: No, I'm sorry. I don't want to jump on your questioning territory, but the fact is that I do find that um, the concern I have about osteopaths are, is that obviously there's a need to earn your income now the need to do patients and help and they've got a very heavy patient load is very important to do as many pages you can. But on the other hand, speed lets you down because my view is that you should, if you, if you treat for 15, twenty minutes, forty, forty five minutes as usual, average kind of time, you should leave yourself at least a ten, fifteen minute gap between patients to write down your notes. And I mean, it's very important that people don't leave it to the end of the day and they may forget, et cetera. So I think it's important to give yourself that time.

APM: Have you, you must have seen an increase in the use of electronic notes and uh, do you find those more useful in court? I suppose useful or not? Depending on what they say, but

Paul: there certainly useful,

APM: but more reliable.

Paul: Not sure if I'd say reliable, but you can certainly track down the position of when, uh, hopefully when they were made as opposed to something which is handwritten. So the answer is yes. The other advantage of course is they could be read. Whereas if you get a letter from a lawyer, for example, outside of the council and with conduct concerned with negligence, then you have to go to notes or oh my God, I can't read my notes, I haven't looked at them properly. It does give you, you see it straight away. So that's the advantage of electronic notes, there's still a lot of people do manuscript notes. That is a lot of people right out there notes as well.

APM: This is a question which often comes up, isn't it? And I have to say that I am very, very guilty of this in my handwriting is almost totally illegible. Almost so illegible that even I can't read it. What is the requirement standard of handwritten notes? If there is such a thing.

Paul: Ah, when. That's a good question because it's a good question because any what governs it says osteopaths and equally so there's another thing for chiropractors and they need other, other, other, uh, I do. I do other disciplines as well and that the psychotherapist, don't have to write up notes. So unlike all the other people, they don't get their requirement but so far as far as should I deal with it as well. But so far as the requirements

concern that they ate it is necessary to have legible notes. It is necessary that it doesn't say how legible they are. So if you can read them and you can transcribe them, that's sufficient. And indeed, um, normally when I, uh, one of the first thing you'd get the complaint they that is the council asks to see your notes and you provide the notes. And they also ask you to transcribe them because they sometimes can't read them. I never had a criticism to say, well, your notes are so bad. They so bad how do I know they are what they are.

APM: When you said, when you say legibility, the notes have to be legible to the person who read them.

Paul: I think that's the answer. That's the answer. I would say if I had the hearing, it's better. Can I suggest that you do improve your writing?

APM: I'm trying

Paul: well I'm as bad as well.

APM: What about then I mean I work in a multi-disciplinary clinic where I might share patients with a sports therapist or a, hypnotherapist or an acupuncturist or there is no. There's no way in the chance that any of them will read my notes accurately. What's your advice there? It might actually be another osteopathy takes on a patient when I'm not there.

Paul: Well, the. That's the standard question. The standard question is you shouldn't rely on other people's notes. You can look at them. Say you are Steven Bruce, you are an osteopath, you are, et cetera. And you've seen the patient on a certain date, but beyond that, it is wrong if you, uh, bearing in mind your insurance policies, backing you up to defend you and big boys and et cetera. Where, whatever age is it, just important. It's very important that you should do your own notes which leaves. The other question, these are standard questions about can follow as a question that people ask me is one is, um, the, the, as far as notes are concerned. Obviously if you make notes and you see a patient within a week or two weeks, then you can rely on your notes. But if you use a, the two, the two exceptions obviously are. One is if you see, if you see another person, another osteopath station, you should make your notes, you can check them. You can say, I can see here that you've got a, you, you fell off a horse when you age twelve, you had this accident. That's fine. So you are checking the notes, but you can't just rely on, read them and just immediately go into treatment. And the other of course is a situation where a patient returns after say three, six months, thirty six months. You can't rely on those notes again. So well actually I saw you six months ago on the table and I'm going to manipulate or soft tissue you, NET you, whatever it is now that you should check again, you should go through them again and make absolutely sure these are very important matters

APM: right from first principles

Paul: Well no, again you can check you've got them there, you can check what your age how old are you now 54 instead of 55 or 55 instead of 54 and you have have anything happen since that time and you should read out to them so they can then compare. Because as we both know as osteopaths practice, I mean practice for a bit of time is that when you start asking questions, I found that when I have to treat that Sunday after the third treatment, somebody said, Oh, you know, I forgot I did fall off a horse or somebody this kickbox that, sorry, this kickboxing kicked me and I forgot about that. For example those kinds of matters that can come to the fore,

APM: I suspect again that that's one of the advantages of electronic notes because in my particular version of a case history, there was a front page which has on it warning signs and red flags and so when we write in, dont manipulate this person's neck because they, you should, um, but of course when that occurs, after the first treatment, if you're going to write it back on the first page is, it's difficult to follow through and keep that information fresh in mind, isn't it? Whereas with electronic notes, I imagine you can keep the red flags very current.

Paul: Well that's right. Well, I, I, I'm sure electronics are the future if not the present

APM: We're getting, we're getting slightly off the topic here aren't we. There's a lot of abbreviations used in, you know, in our work, um, how do they stand up in court, which ones we're allowed to use, which ones we not allowed to use.

Paul: You can use obviously the standard ones are the fracture, for example, the right left. All these kind of events. The why, that's why possibly I lean towards if you can read them and you can explain them to somebody else, I think that suffices what I suggest to my clients when they come to me, usually they come to me and they've already after the event a, they're not doing five people would how to put documents together, but normally I say have a glossary of all the common term to use. Keep them there. So if you ever request the notes, then you can immediately refer to a glossary. Otherwise you could be accused in cross examination in the hearing while you're making it up. You'd just say, and it's not very funny, medical acronyms which has which you've got there, that they where somebody you can read one way. It says patient not well otherwise. Patient mental it all different kinds of say so be very careful how you do your, your, your, your

APM: very popular list which has been going around on the Internet for years.

Paul: Google them your listeners can see that? The very funny medical jokes is that they're very funny but not to be used here no.

APM: That strikes me. I can't believe you haven't been asked this in court. How will you to know if was using manuscript notes by the time it comes to a disciplinary hearing, or court. They haven't amended the notes to suit what they want to be heard in court.

Paul: Whether they're. They're very, they're, they're, they're that fantastic case that came out in about 2000 were a doctor used to use a Lloyd George used to have these brown envelope type things. You used to write your notes. The GP's did. Lloyd George Cards, they're called Lloyd George Cards and this person, this child who the case was brought by the parents because the child had meningitis and the doctor didn't spot it that the child went away and it could've been prevented. Anyway, the point was that in these notes you saw, um, the, the, all these notes, very short note. And then we came to the particular event. When the doc, they patient attended the young child attended. The doctor a very long detailed, you know, an exactly And it was brilliant, you know, very, very good. But what a very acute lawyer, wasn't me, acute lawyer. At the medical defense, at the, um, at the GMC having on the GMC that came into a negligence case, but where they spotted, but the Lloyd George Card he wrote on was a one that was brought up after the event. In other words, say they saw the patient in 2000, we came to 2008 say. And the notes were the new form formula of notes was 2004. So there's no way he could have written those notes on that card. It didn't exist at the time.

APM: But we do wait sometimes to write our notes up don't we until after the appointment. Maybe not years after.

Paul: Yeah. Well, I certainly hope not, but they actually are. Sorry Im not sure if I answered your question

APM: well you did in that case, if it's clear that there's a piece of maybe you couldn't have used, but actually I'm not sure. I'm not sure if anyone's ever done this that you've represented or you're aware of it, but it's handwritten

Paul: easily can't tell. But what you must do, the cardinal rule one is that you should, um, if you make any amendments you should initial them, but you should put a date to them. And in fact, I suggest everyone, if you have written handwritten and are moving away from electronic, then you should certainly, I suggest you read them even if even if instead of watching television or, or going out, going out and going to the theatre or what have you, spend a few minutes just go. Through your notes, because it could be you can make errors in those notes and you correct them and correct them I've known corrections made. But I had one case where a GOsC case with a PC, a case of disciplinary case where they did pick up my client because she wrote on, she wrote her notes or change the notes about, about, uh, about a week later and they took it very badly. So be very careful in that regard. So in other words, in short, have your notes look at them, you can amend them, you can have you, as long as you put a note. I changed it, cetera. Why? And you can justify if you're asked the question, why did you change the notes I changed the notes because I re-read them. I realized that I was not correct on that. Whatever it is, or you can go back, you know, the, I gave this diagnosis but I now realize that my diagnosis was wrong because an app and you put patients on something else so they're worried about notes you have the notes as long if you change the, make sure the, as long as you're honest, the most important, being honest, change them, mark them, indicate that you changed them, you changed them.

APM: Something you said earlier on that Made me wonder whether we're actually working on a level playing field. And I know that the, unlevelness of the playing field is no justification for not doing things correctly. But you said if you haven't seen a patient for two or three weeks or two or three months or six months, make sure you ask them screen all the questions. OK. Actually, I've been to doctors a year, two years after they previously saw me and I've never been asked questions like, is there a. We aiming for higher standards in Chiropractic and osteopathy than the GMC asks of its practitioners.

Paul: There used to be an expert, a lovely. I won't, I won't I better be Careful about who I, who. I say I, I have great respect for, but he always used to when we were first doing cases because when I first started GOsC he was there at beginning, they're representing a osteopath, but she always went for the gold standard and we always the gold standard, it's not fair, you know, obviously that's the gold standard, but all required under the law in the uh, council that we're talking about either civil case or criminal case or to just a civil case or a disciplinary case. We're looking at the average standard the reasonable standard which is called Bolum which uh, would you can still apply here, it's an old law of other things consent but Bolum is OK for that. So therefore you are in a sense right, but your, you talked about the comparison with between a doctor, an osteopath, but the question is that this doctor is not going before, uh, for PCC. So you do the API, you should try and aim for the gold standard if you can

APM: What happens with PCC, the professional conduct committee,

Paul: what happens?

APM: If I, if I were accused of something, a complaint had been raised and what would it be? The procedure for me as a jobbing osteopath

Paul: and getting through the whole procedure in short, or should I just say when you've got that, you've got to that point?

APM: Outline the preceding bit and then tell us what happens when you arrived.

Paul: What I can tell you from the complaint onwards, you want to. Well, what happens if a complaint is made by a member of the public or, or it could be a fellow practitioner and they report it to the General Council. They have a team of a little maybe, so they had lawyers and barristers who work there. They're very efficient team and they would first of all monitor it. It will then go to a, a first go to a screen up who is, uh, uh, they, they train osteopath to who spend a weekend on a course for to portray and they were, it's a proper question or whether that comes under a, some kind of rubric of some breach of the standards. You then having done that, you then get a letter from the, I think the forces within the compiler of osteopathy and the ops practice standards. Then you get a letter unfortunately say I'm very sorry to report a complaint made against you. Here's the, here's the, here's the screeners report. He reckons you are in breach of ABC. His, his email or statement always have usually a statement and you got a chance to respond.

APM: my ABC will be the osteopathic practice standards or chiropractic standards.

Paul: Exactly, exactly correct. These are standard and therefore you've got twenty eight days. What then happens you must do is um, uh, besides taking a strong whiskey or whatever is your brew, you should go along, speak to your insurers there are different insurers around and you got to show it and they will either help you directly or alternative refers to a lawyer. The way that it's not a plug for Baylons the way Baylons work is. other ones that they use the lawyer straight away. There is Baylons. They immediately, refer it to me and I have my team will come and people working with me and we would immediately vet it we will advise the, um, we will advise how to write the letter. We'd write the letter for the person, we may meet the person, the osteopathic centre or the chiropractor, and then give a response. The response then goes off and then they, then there's investigation committee that meets them a few months later. Read through your response.

APM: Whose on that committee?

Paul: Committee is about, usually it's number of law, a number of osteopaths and other legal assessors floating around who's also a lawyer. It's usually made up of five people I think it is. And then the additional and the layperson as well involved. Um, and what happens is, is that I should also mention that you, the complaint comes in, you respond to it. Your response might go back to the complainant, but could play then responds back further. There's a bit of an interplay there. It goes, the investigative committee who decide whether or not you've reached the threshold. You can google a general osteopathic council threshold criteria, but unacceptable professional conduct because the crime that we lawyers that we osteopaths commit is only one thing unacceptable professional conduct. Consequently, the investigative committee that looks, that looks whether or not there's what we call a prima facie case. Is there a basic case or not? If it's a contractual case, I'd say they won't touch it and certain things they won't touch, but if it touched on osteopathic practice or reputation and so then they decide

APM: when your contractual case, what do you mean?

Paul: when necessary You're just suing for money an osteopath and you had to build a builder who uh, and you haven't paid the builder and the builder sees money, then they won't touch it. But if it brings into osteopathy or somehow they know you're an osteopath, they could touch on it. Then the irony of the investigative Committees say thank you no case and you're relieved, or they've actually, we're sorry. We've now found that you have just the threshold and we can take it further is then taken to you. Then get a note. Say you'll now be, there'll be hearing in, whatever time it takes a it could be heard in two or three or four or five months time and then you have to gear yourself up and then they come back to me or with other lawyers dealing with it, with your insurance company refer to the lawyer and then you gear up. You then get eventually a allegation sheets it tells you what the allegations are or the evidence against you probably an expert's report as well. Come subsequently. And we. And then I prepare a response. I meet with the osteopath or Chiropractor, build up, build up and eventually

there is a hearing before the professional conduct committee. So very short how it

APM: Right and then you arrive for the hearing with you professional conduct commitee.

Paul: you arrived to the committee. It's usually at Osteopathy house at the Tower Bridge road. They usually have some other places but normally not needs a big conference room. They use for everything else and there's committee there of a, of a illegal assessor who's usually a QC, a queen's counsel that's a barrister among ten years qualification because the QC is a very good, a high quality and um, they have a professional conduct committee made up of three, a one les two les, les means not osteopaths, so you could be a banker, could be an accountant, that could be a public official, et cetera. And you have one osteopath and they're pretty good. They're quite good, they're well trained and they're very polite and you go in the room. There you go with your lawyer. You sit on one side the prosecutor on the other side normally the GOsC bringing in an external barrister that have a good team that it's all very well handled, is very horrible experience, but they are very fair. I can say that the conduct that is very fair and it's all handled extremely well. The very politely they will in effect Welcome him in. Hello Mr. Grant, I know you're the osteopath. This is our panel. We're now going to hear the case, the case against you, et Cetera, et cetera. Now, unfortunately it's in public, which means that people, the public can attend, but in all my sixteen years or seventeen years since they started, I think I only know of one member of the public ever come in and I think they thought it was a, a theatre and then walked out again. So I've never been in public stay in there but it is in the public domain

APM: and I ask for completeness. Here is the procedure pretty much the same for chiropractors?

Paul: It is more or less Yes. The.

APM: Can you Google that threshold for complaints with chiropractors

Paul: they don't have a threshold. I don't think I've seen the fact. Certainly osteopaths have the threshold, you know, something, I'm not sure whether they do have that same document, but it's very similar because based on common sense principles, I mean, for example, uh, uh, for example, they were the osteopath who, who didn't, who, who had big argument, a fight at a petrol station now thats innocuous, but somehow or another he, he, he, he had had a big osteopath on his car, I think the side, et cetera and so forth. And they were therefore, they're always bad reputation of osteopathy. And therefore, we did go to the piece. They did go to the council for generally

APM: And how did that one end up,

Paul: I think he got a war- uh, I think you got a warning in the end. It's not good because it's not, it's not terrible,

APM: Well I ask out of ghoulish curiosity but also there are circumstances when one might get embroiled in all sorts of problems and you would hope that it's just being involved in fight isn't sufficient.

Paul: Usually it isn't but there was other things added to it. So he wasn't, he wasn't totally totally that or not paying. They're not paying the fare. But then as an osteopath, it looks badly. Are these the osteopath? It's very, it's very small.

APM: We've got some questions coming in. So we're going to turn to the electronic notes seem to be quite popular. The electronic consent is a key point in the digital, note keeping. Where do we stand in sharing or gaining confirmation of consent with notes? Is a tick-box enough.

Paul: Uh, that's a very, that's a question often asked and I understand it. I one thing I can say to you, I cannot guarantee that whatever you do, they, they, it will be absolutely one hundred percent that it will be confirmed that that is sufficient. Certainly, um,

APM: Such as the law

Paul: what?

APM: Such as the law

Paul: Such as the law. The point is it's a matter of who do I believe I'm the patient. Uh, Steven, you didn't get consent from me. You might have ticked your box, but it's not true, you know, it's that kind of situation. Right? So therefore, I argued recently where they said tick-box most efficient, one of the members of the uh, committees. So I said why my client does it is a reminder to him that he did ask the question, but you did get the consent. So therefore I would say that it's a good idea to have a tick box because it does give you some indication that there's a lot of controversy over the years over tick, tick boxes. Some people that, one client of mine or two that might have stamps that consent gained and they stamp every time they, they do a maneuver or they do manipulation or whatever it is.

APM: And I think I'm a one on one of our very senior men, Lawrence Buckner. He uses C in a circle with a tick through. I think it means C means he's given me information, circle confirms and the tick is. Just reassurance that the actually gained informed consent from his patients.

Paul: And I work very close together. He, he does. He does a lot of work for me and others. He's, he's very good indeed. So, uh,

APM: but again, he's got consistency. Hasn't, it's the same. It's the same in abbreviation or symbol every time, whenever he needs to get consent. Um, we got very friendly questionnaire here. Probably one of those who said they were on mulled wine earlier on, whoever it is. I'm sorry, I don't know your name and says hello. How much detail is required in the notes? I

always write the notes in front of my patients during that treatment session so that all my patients could agree that if asked.

Paul: Thats very good! I remember i once went to a dentist. Um, he was too expensive. So I left and went somewhere else, a bit expensive. But anyway, he is in fact fantastic. He was talking as, as he, as he spoke, he had his nurse there typing it all up, so it's, well had my mouth open and I was gagging and I saw the notes that being typed out in front of me, so I was probably quite good as well. I'm not saying I should have your mouth open or be gagged or, or go to dentist who.

APM: It sounds a bit difficult to consent.

Paul: It is difficult to consent, you know, you try, you try, you try to answer the question to a dentist, your mouth and it's a difficult.

APM: The next question is if you've got consent forms at which point should a patient sign them and I think consent forms themselves are quite contentious issue aren't they?

Paul: Well there are different consents aren't there. The first thing is let's start with consent. The consent is OK, we've got different areas consent. Let's, let's break it down. The first is whether or not the patient undresses or not. For example, and there are what I suggest certainly very strongly is that you, uh, this is my mantra to everybody is that you should, um, and that their notes, Are there ways you've can, they're the company that produce these, these, uh, a document, et cetera. Within my firm, we'd be, we can produce these kind of documents, et cetera. But what happens is, is she is a volunteer before the patient comes an email is now very prevalent, is to email or write or communicate in some way before you come into. They are aware of what the situation is. So therefore they know that part of the treatment involves undressing, for example, and they also know, they're aware that they will, it could be all sorts of a problem, for instance, as we know with regards to manipulation. So I think they get some warnings somewhere in advance because otherwise the pay it was because the way I look at matters is because I'm at the uh I said at the, uh, the, uh, the coal face, uh, I seen the worst and therefore what I'm saying to you to prevent it. So therefore the answers, uh, certainly you can get a form before the - When the patient comes in, I will, I will suggest that like in a, like a dentist I see a lot of dentists you say is that they give you, they can be a form and they say, can you tick off the boxes and have you had heart problems? Have you got this, that and the other, and that is useful to you because when the patient later on says, well, you know, he didn't know you could say, well, you wrote it down. You have, I wrote down, you have no heart problem. He has no.

APM: How often would you have to fill in that form every time you came

Paul: the first time around, the first time that say, you know, that basic condition, right? That's one. And then afterwards they can get the signed a form saying that they say, sign that form that they as a medical condition. That's the first

stage. Now. So the next stage of course is um, uh, uh, it's the actual clinical treatment right now. Then it comes a bit more contentious because when do you, when do you get consent?

APM: if you've asked us a question about consent and there are several on my list already, please bear with me. I'm going to ask a little bit later on. We're very conscious that we have two guests in the studio this evening and I'm concentrated for the last fifteen minutes on just one of them and of course the important parts about consent, the informed by informed consent and that's I think where Jo our next guest comes in. I should first of all say actually somebody here who wants to blow smoke up your trouser leg because whoever it is says Baylans and there lawyers were brilliant when I had an advertising complaint made against my website and I don't know who said that, but thank you for that. If anybody does need any advice on which insurance company to use, then they should give us a ring at the academy and we will tell them to use payment because actually we have a discount with Baylans and they use Paul in a trained osteopath as the man to defend people in court cases. And all our interactions, with Baylans have been absolutely first class other insurers are available. But, um, but let's talk about informed consent. Um, well, I'll start with you again because what do you, what does the law mean by informed consent?

Paul: Informed consent is a concept that was brought in by America about twenty years ago. We never, we, we, it was, it wasn't the term he used in English law. Informed consent obviously means that you inform the patient prior to the whatever you intend to do, of what you intend to do and what the sequences are, what the risks are. So you've got to inform the patient. I can talk a long time I expect you don't want me to talk about the case of Montgomery, which is the most important case in the last two years

APM: Can you do it in a condensed form because I think that the Montgomery case is quite important because it's superseded another one, which was

Paul: the reason why we talked about Bollom, Bollom is dead as far as that's concerned. Informed consent. The Montgomery case in short, concerned a lady who was heavily pregnant in Scotland who, uh, who was diabetic, a very small stature and it's well known apparently, but if, if you, if you're, if you, if you're pregnant with a, a w and your diabetic, and you are a small stature is more likely the child can be Rather Large, which means when they come down the birth canal, various problems could arise. And there's the, the, the problem with regard to, um, the uh, uh, cerebral palsy because the child could be, you could get the cord round it and there are other matter at all, the, the s, the specialist who's very highly recognized. Specialist took the view that, um, uh, took the view the view that it should be normal, a normal birth because she there's a whole lot of the whole controversy. Why? Because she said, uh, the other way of doing it as a c, a c, c section that cesarian, uh, unfortunately the worst comes to worst. The child, uh, receive cerebral palsy that the cord wrapped around the neck, et Cetera, et Cetera, et cetera. So this case, the, the lady brought a case against the, uh, the, the, the, uh, Lanarkshire council who were the responsible for the doctor and the, uh, the, the uh, a hospital and uh, went to the Supreme Court and the

court decided on the majority, not, not every judge but the majority that you have to, you have to really effectively inform the patient of everything you could assume that patient is sufficient, have sufficient knowledge in order for you to impart total information and you shouldn't use, didn't, shouldn't hold back, which makes it very difficult and I'm sure thats another question about cervical manipulation, but that makes it very difficult for us. But nowadays I can give you lots of stories about that,

APM: but we'd like to hear those in a little while, but this is the point in which I want to bring Jo in, because Jo, we've been talking for quite some time about what lawyers think about informed consent and communications. Now, as I said earlier on, you were diagnosed with aspergers at Twenty three quite Late on, but could you explain to us how aspergers makes you feel? What, what effect does it have on your life?

Jo: Well, aspergers, affects every area of my life in quite significant ways and quite often those ways can, look quite subtle to other people because there not obvious and because I'm quite intelligent, not meaning to blow my own trumpet or anything, but um, my intelligence levels probably the reason that I got through most of my childhood until I was in my twenties before I was diagnosed. Um, and really it's things you don't think think about because you take them for granted. It's things like being able to pick up the telephone and make a phone call. That can be really difficult for me. It's things like when it snowed and your plans all change, you can just make new ones and carry on with your day. Well, I couldn't when it snowed the other week and, all my plans changed. It kind of ruined things a little bit for me. Um dealing with all kinds of change can be really, really difficult from like an event through to just how I feel inside and even when it's like a happy feeling that can be difficult to deal with if I'm not used to it. It effects executive functioning, which is the ability to plan, organize to judge how long things will take, um, like they call it the executive functions because it's what you would assume an executive in a business would need to be able to do to plan their workload, um, effects central coherence, which is your ability to see the wider scope and bigger details rather than just focusing on something really small. Um, and it also affects how you can take perspective. So that can be the way another person would see things, but it also can be how you see things, how you would view a task and what it meant and what you were trying to achieve and whether you were capable of doing that. There's also, um, sensory impairments and differences that are associated with autism, which I find quite difficult. Um, things like bright lights and loud noises on a really bad day someone flicking the light switch on can be quite painful to me. Um, there's people can have difficulties with touch, with taste, the smells, I'm proprioception you can have a hypo or hypersensitivity to proprioceptive input. Some people would seek proprioception for calming reasons and vestibular issues as well you can have and the interoception also can be affected, which is whether you can tell you some things hot or cold weather you're hungry. Whether you can sense pain,

APM: you have an interesting relationship with pain.

Jo: Yes. Um, I, um, don't always recognize when I hurt myself when I was eleven years old, I walked around for a week with a broken arm before it was put into a cast, um, as a kick boxer as well that it has some benefits, but it's, um, it's not always a good thing from an athlete perspective of if you injure yourself and you should be rested and you continue to, um, participate in sport, obviously you can do further damage. Obviously if you've broken your arm, you still walking around for a week. That could make it even worse and cause complications.

APM: Does that mean for you that in clinic, if you were to see me for example, and I did something that was painful, you might not recognize that sensation and be able to tell me to stop because obviously we would ask a patient. Normally if it hurts tell me and I'll stop

Jo: Yeah, it's kind of two fold there's first having asperger's also defined as a communication impairments. So I find it really difficult to express feelings and preferences to things I might like or dislike and just general communication. So first off there's a difficulty in expressing if I felt something and the case has been when, when I've been to a clinician treatment to do an assessment, I'm, uh, generally at a practitioner will be palpating you, moving you, looking for a reaction. And often with me you won't get a reaction. You won't get any tension in my muscle because I don't feel it or because I don't express it. So you're not getting the verbal feedback. You're not getting any indication that that might be tender or sore. And I don't know that that's what you were expecting me to feed back on, so I'm not giving you that feedback.

APM: You were talking to me earlier on about being examined. I think that you said the circumstances were stressful and a practitioner, nurse practitioner, someone had told you to, um, pull her arm or resistant movement.

Jo: Yeah,

APM: and that didn't go the way she planned.

Jo: Practitioners and health professionals have a great time when they get to, um, have an appointment with me when I'm more stressed and anxious. I can lose my ability to speak, but I can also become more literal in my understanding so things that I might otherwise know, they can't mean literally that might take as being literal. And in this example, um, I'd hurt my arm and the nurse asked me to pull her arm towards me and I interpret that as, as hard as I could rather than just a little bit to test if it was painful because I don't feel pain as much. It wasn't as bad to pull it as hard as I did. Um, so there's that. And then also have things like where a doctor would ask me if I'm allergic to something, meaning something within hospital, like a medication I come up with something like horses because I'm allergic to horses when I'm not going to encounter one in hospital or maybe your clinic for me.

APM: Well you can never tell with my wife who's fond of dissecting the things. So in terms of getting informed consent, I actually should say, I didn't mention

this earlier on, but you are actually terribly remarkable because actually you're a qualified sports therapists.

Jo: Yes.

APM: I imagine from what you've told me that to attend a course like that is hard enough, but to pass a course which de- which demands, um, interaction with other people on the training with lots of other people must be quite challenging.

Jo: Yes. Um, yeah, it wasn't the easiest circumstances I had when I did the course either at the time, um, I think I was going to Canada for world championships. So the month of my exams, the start, the first half of the month I was in Canada fighting in the second half I was doing my exams, but then like three or four months before that, I'd torn my hamstring. So I had a grade 2 hamstring tear, um, had been off my feet for six weeks.

APM: The reason this is important is of course you understand the concept of informed consent as a sports therapist and we were discussing this earlier on. I think, um, how does it affect my ability as an osteopath or any other practitioner to get informed consent from you? The fact that you have asperger's,

Jo: um, my communication can be unreliable. So particularly when I'm more stressed or anxious, which can happen in situations that are unfamiliar or new or where, I'm not sure what to expect. So what this means is that when, um, when you're trying to get consent from me, I might just give it to you but not actually understand or process or taken in any of the information you've given me. So, um, there's times where people have asked me if I'd like a drink, for example, and I'll say, I don't know, which sounds really weird because how can you not know if you'd like to drink or not? But I couldn't answer because I didn't know what the options were and if the options were not what I would like, then I didn't want to then go back and say well actually, no, I don't want more now because I don't like what you're offering. So, um, to be able to answer the first question, I have to know what the options were in the second question. Um, so from that perspective as well also sometimes if I'm not comfortable around somebody I might say no to something because even though I want say a drink I'm not comfortable having a drink from you. So rather than say yes, I'd say no, but actually I might need one so it can be unreliable as to working out what actually is that of, um, understood or what I actually want.

APM: I'm going to come back to you a bit later on to try and work out how we fix those problems in clinic because I am really embarrassed that I didn't know an awful lot of the things that I've learned from you more recently about asperger's or autism generally. Um, and I think there's lots we could have done in our clinic to make things better. But Paul, in court or at a disciplinary hearing. Um, have you experienced have cases where a patient not necessarily with, with autism asperger's but has got challenges in understanding the things that their practitioner has said and therefore could not have reliably given informed consent

Paul: Well yes. Absolutely. I mean there are cases which I've read about as well as I've encountered that I was just hearing Jo's a account is extremely difficult for a practitioner dealing with that. Unless a question may be asked, well, how do we deal with this? And I'll let you want to unscramble that. And I'm thinking, well, are you talking? How would I am scrambling? And I would say again, what would a reasonable osteopath, uh, do? I have quite clearly, um, unlike Jo here. But if you had somebody who was a friend whose daughter is clearly autistic, which I quite clearly very challenged in that way, it's quite obvious. Therefore you would want possibly the guardian etcetera that Jo Jo's totally autonomous. I know that but that they would. But then how do you know when somebody is that, that kind of situation? Well, that's why it's important for you to listen very carefully to what the patient says and if they keep saying, I don't know when to question, that doesn't make sense to you, then you should possibly be careful in what you do. So you either go very simple and don't go manipulation, and do very many soft tissue, et cetera. But the fact that I think if you can show to the court or the tribunal that they would know manifest signs to show that person was in any way outside of the normal range if I put it that way, then I think you would be, it would be OK provided you went through the whole proper mantra of obtaining informed consent.

APM: Jo when you go to a new practitioner and I can't remember how long ago you first came to my practice. Do you tell people before you arrive that you have asperger's?

Jo: Usually, yes. Cause, um, I can be unpredictable. So whereas now, I'm sitting here and I'm talking normally this might not always be the case. Um, and for me sometimes when it comes to taking information from me, the recall that I have of events can sometimes not be quite accurate. So it's like, you mentioned earlier about somebody coming back, oh well actually, I remember this happened, I'm very much like that, and I find it very difficult to judge what's relevant so you will get, um, all of the details all at once even if it's not relevant. So I might tell you that I sprained my ankle, but at the time I was in a fight and I was doing this and this happening and that happened and it might be stuff that is interesting, but it's not essential to what you need to know. So I think when I learned how to do sport massage, it was, eye opening for me because it gave me a process for the information that I needed to give to a practitioner who was assessing my injuries and that I found really helpful because it became apparent to me that I needed to give information on when it happened, how it happened and all those kinds of things. And then also that feedback on whether something hurt or it felt slightly uncomfortable as sometimes if it feels different to me, I know that might be it hurts and it's worth saying I can feel something there.

APM: I remember when you first came to my practice on several occasions you had your husband with you. Was that because having a chaperone helps in the communication process?

Jo: Yeah, mostly whenever I go to an appointment I usually have a person with me. So it's actually quite good that I come to yours without one.

APM: I felt flattered, I genuinely felt really flattered.

Jo: So that means that I'm comfortable communicating and um, I can, I know I can contact in other ways if I need to ask any questions. So, um, generally I take someone with me because I also forget what people tell me to do. So when they've said like, you know, go away, do these stretches or go and do these exercises, make sure you ice this two to three times a day. Things like that. I'll forget to do that. And I will forget, um, what exactly I've been told to do or what problems there might have been. I think if you remember when, um, I first saw you, you wrote on a compliment slip what you thought the problem was, so that I could go away and read it. So that was actually really good.

APM: Thank you. That was an accident I expect on my part. Um, in your, when I read your, your notes beforehand you said that unusual situations can make you feel anxious. Crowded waiting rooms make you feel anxious, bright lights make you feel anxious and when you become anxious and then your communication skills become impaired. How, how do we deal with that in one of our practices? Because if I come and fetch you from the waiting room when you were already anxious I'm gonna have trouble aren't I with my doing my job?

Jo: Yeah. I think um, when you're adjusting for people with autism or any kind of communication impairment or some think that impaired, like what sort of, even just for anxious patients who, who might be a bit worried about coming to see you. What you're trying to do really is to take away some of the elements that are going to cause anxiety. And that can be an unfamiliar situation, um, that can be making sure expectations are clear and it's generally just putting in place sort of a process that you can expect to happen. So I think for example, coming to your practice, because I've been there so many times, I know who I see in it's familiar, I know the process, I know what to expect when I walk in sometimes when you change things around like where the waiting room is that can kind of throw me a little bit, but it's still a familiar place that I have been in to before because it changed in another room and I visited. So, um, there's a lot of things you can do and I think also Paul kind of touched on that, that kind of thing. It was making things, making information available before you go to the clinic. So you've got your um, websites you can use and put information on there which can detail what's going to happen from when you enter the building to when you leave the building and you go through it on a step by step process. So you put yourself into the shoes of your patient and think, when I arrive here, what do I see a door, do I can I walk through it and we'd have to ring a bell. So that's your first step then it's when I go through the door, who greets me? Is it going to be a receptionist or do I have to find my own way to a waiting room? So you go through each step of an appointment in that way and as if you don't know what to expect and you can raise quite a lot of questions which will then help you to provide information that can help your patients.

APM: That's, I mean we're all advised to give guidance to patients before they arrive for first appointment to, to let them know what to expect. But what

you said goes beyond what we would normally do because we would assume it's obvious when you arrive at the front door and ring the bell and someone let's you in that doesn't really matter whether it's a receptionist or a practitioner or will you just open the door and walk to the waiting room? Um, but it's really useful to know that that would help to calm somebody with asperger's or autism or on first arrival. I think you did share with us. Share with me earlier on a list of things which you felt were useful for people with aspergers. Can I, can I share that with our audience? Later? Just put it on the website. Um, I think everybody will find that very, very helpful. One other thing you mentioned in there is that you don't like not knowing when your appointment's delayed and you don't like not knowing if the appointment is going to run over because she'd like the certainty of knowing like giving a 10:00 and finish at 10:30. And yet you just said earlier on that if you were asked a no longer yourself but if someone with aspergers and ask the question they might run on for a long time talking about the circumstances around that. So we might end up with a longer appointment. Are you OK if I, if I were to say to you halfway through an appointment, look this is, this is going to take me a bit longer? We wouldn't be finishing until twenty too. Does that settle your nerve or your anxiety?

Jo: Yeah, that, that would help me, but it doesn't always mean that would help every other person. It can be a very individual thing as to what a person needs. So if a patient were to disclose their diagnosis, the best things to be to ask them what they need to help them because sometimes they are where sometimes they aren't. Also just general adjustments if put in place can be helpful whether they've told you or not. Um, and I think I mentioned as well about a lot of visual supports and that's something that I didn't know that I needed until very recently and that really helped me, um, to have those. So that can be things like having, um, picture systems and like for example, if something. I think I said if something hurt me or if I wasn't comfortable with something, I wouldn't be able to tell you that I don't like that. I don't, I don't feel comfortable with it. I would like you to stop before I had a card or something that I could hold up or give you that would then communicate to you that that was what needed to happen. Then that would make that easier for me. I think it also said about having something on the wall that would, could kind of go through the process of what to expect. So for example, during assessment, observation testing palpation and like kind of a checklist almost visually that that's there, that can be reassuring of what to expect from, um, an appointment,

APM: And a video, that sort of thing on the website. Presumably. Would be useful as well.

Jo: Yeah, it's much visual information available in as many different formats as possible is beneficial.

APM: You did make the points in your notes that actually when you're anxious actually your ability to read gets worse, but you can still interpret the pictures better.

Jo: Yeah. I kind of stopped being able to process the written word, but I'm seeing a picture with the word binds the association so it helps to know what to do.

APM: Now my team are going to be very cross with me now because I haven't warned them that we need some special camera work. So you brought in, you've actually brought in a couple of things haven't you, but we'll need to get a close up with the camera for this. First of all, you got something in your hands there which you said is really useful for helping soothe nerves. Is that a common trait with someone with asperger's?

Jo: Some of them like an ADHD and anxiety. I think everyone's heard a lot of the fidget spinner and people think because they're quite annoying. It's like a the latest craze, but actually that was designed for people with additional needs for classrooms. So it would help a child with ADHD, um, sit in a classroom and concentrate because they were occupying their hands. I think I kind of discovered that things like that helped me when going through super markets, which I found quite stressful. Having something to direct through my hands, took the anxiety from up here in my chest and in my mind into and through my hands. And it kept me busy and took the anxiety down

APM: If that's useful. Are we entitled to expect that an Asperger's person will, will bring their own device with them, should we put them in a clinic for people to play with

Jo: some, some people might bring them with them. Um, and other people might not. It's something that's becoming more prevailant now and more acceptable now to do. Whereas I think before it might have been looked upon as why have you bought that for what you've fiddling around with that you're not listening to me actually having something to fiddle with helps me to listen because I also have ADHD so I'm I loose attention and get distracted quite easily. So I'm like, I don't look at people in the eyes because uh, also stops me from being able to hear what you're saying so people can think, oh, you're not looking at me while I'm talking to you. But actually it's so that I can talk to you. I'm not looking at, you. Yeah the, the fidget toys, they, they help with, um, calming. And it can be stuff like different textures. Like I like fluffy things I find that quite calming against my skin, so holding that or like stroking my dog and that kind of thing can be quite calming to me. Um, there's like a whole range of stuff, but having some available in, in a clinic would be like good. Um, but like for some children, particularly with autism or asperger's, you might struggle to get them back. So there's a flexibility to go OK, well that was only 20p so they can have it kind of thing or the parent might manage to wrangle it off them and bring it back to the next appointment. Um, like I think it's quite that quite cheap to pick up if you know where to get them from and stuff like that.

APM: The other thing that you brought in with you is, um, a couple of sets of cards which you mentioned earlier on that you could even in position to where you couldn't communicate that you want someone to stop. You might be able to show somebody a card, are these commonly used by a asperger's?

Jo: Um, yeah, like it's a form of a communication aid. So, um, if you can't tell somebody that you're struggling or you don't understand, you can have. So these are communication fans this one's got stuff like I don't understand or I need timeout what I need to know what's next?

APM: Could you just hold them up? a little while. You just hold them up a little bit higher Jo. So the camera can see that. Don't hold up the one that says I've got to stop talking.

Jo: My favorite one and that one you just stop talking. Um, so yeah, so those things can be quite useful for. There's lots of different versions you can get that, um, I need. And that's kind of different things that you need. This is a sensory one. So for someone with the sensory impairment, it can be used to, you can either kind of, if you had it, you could present it to them. If they sort of lost ability to talk. I can't talk, I don't always think oh I should bring out a communication fan if someone was with me and said, OK, it seems like you're struggling is some, one of these an issue and held them out I might be able to kind of go, yeah, it's that one or it's that one. Um, hopefully it wouldn't be so many when they came to visit you. Um, but sort of, yeah, so you can have sensory ones, there's ones for like emotions. Um, I also have a communication passport which I sent you as well

APM: Which we'll share with the audience through the website.

Jo: Some people find those quite, quite useful because it can detail the things you might find hard, what can be done to help or remind them of what they can do to make it easier for themselves. Um, and it can also, it can list all that stuff that you'd need to find from a, from a patient as well. So they could put on the significant things like, I don't like being touched in this area or I find it difficult if I hear people breathing in my ear, that kind of thing. So you might be more aware of those things when you're treating them.

APM: There's a lot to think about there Paul isn't there in terms of getting informed consent and making sure that our patients genuinely understand what it is we're, we're doing and that they're not anxious about the whole process. Um, we'll come back to some of your interesting cases at some point, but I have got a whole heap of questions I need to throw out. If I can. This is one I've seen many times in meetings I've been to. Does attending an appointment provide implied consent that will be adequate for treatment, excluding manipulation. So how has that actually been tested in court?

Paul: No, I don't think hopefully most osteopaths have sufficient intelligence to realize just the attendance alone doesn't mean that there is consent to everything set. Even saved manipulation, manipulations. I didn't realize I had no idea when I came here. I had no idea what osteopathy is about I've come here. I had no idea as Jo says, I didn't know what was happening in the same way It's quite interesting. I find it fascinating what Jo said. I like to develop it more with, to talk to you another time, but it does it. What she said is really a microcosm of what we should all be aware of anyway because we're all people who don't know, we know what osteopathy is, but we go to a specialist, we go on on various places. We, we're ignorant of it. We should

be communicating. We should be educated before and during the time that we are with especially, et cetera. We should know it and therefore when you a lot of people don't know what osteopaths do. And if it is right you should know that there's a process involved with the sitting down. There's a speaking as a, as a whole process. I think it's very important.

APM: Following on from that the next question is, has consent always got to be written or spoken or can it be implied if the patient gets on the table after an explanation of the procedures? That will be.

Paul: Absolutely, the answer is yes, but obviously you break it down into it doesn't require written, don't need written consent. It can be oral consent, which means yes, but the question is, is how you say it, and uh, the answer is there are certain things where the case is where, for example, we're not talking about a manipulation where you do need more than putting your neck out and doing something but many, many times that, you know, somebody says, well, I've got a bad arm here. And then you say, and you may say, well, I want to treat the arm and the patient moves the arm out towards you. That's implied consent. It's somewhere where implied means that it's quite clear between the two of us. There's a communication which says, yes, you can go ahead with it. So the other things you've got to be more careful about, but I think that you should really, as a where, we're the speaking profession, I think the foul osteopaths should not exist. It should be, it should be. Oral Oh, you should be able to say, I am about to do this. Can I do this? Ask. Because it's good for the patient. It's good communication and the patient will come back to you. That's very caring osteopath they checked everything

APM: Well you say it's good for them but Daniele has sent in his observation that you can imagine the situation where a patient is lying supine on the table waiting, cervical manipulation and you'd say, Oh, I just need to warn you that I could cause a stroke or possibly even kill you during this. Is that all right? Can you imagine the reaction and his comments is, that's ridiculous because you're actually frightening the patient stiff

Paul: Yeah there I used a quote in one of my lectures that the, the, uh, the Australian Chiropractic or the physiotherapist society says, the worst thing to do is you got your patient on the plinth and you got the, you've got the hold on the patient. They got ahold of the patient and say, look, I shouldn't. I'm just about to manipulate I should warn, you know, obviously they're having the quote was something like, you could feel the muscles slightly tighten when you're, when you're about to do that because the risk, no no that is a very difficult question. And the great criticism, I mean I'm obviously a member of GOsC I'm non-practicing, and I think they're a great organization that's given us a lot of, uh, you know, providence and

APM: That's going to spark some feedback.

Paul: But I do think obviously it's given us a lot of the, I accept that it's controversial, but the point is that the people do. I'm not, I'm not batting for the osteo, but their whole means all, if you read the read this article in the

osteopath is the reputation and to protect the public it's others they look to for, others you must look to for protection. So the answer is there's a lot of people say the general osteopathic should produce words, videos, et Cetera, how to deal with the consent. They don't because they don't think they have to. They write good articles. Steven Bettles wrote article about a month or so. Very good article out as everyone's should read it, he's, he, he writes very well and they set it up very well. But ultimately in the day to day session is very difficult. So the answer is to that particular question is much, much, much more to it. You could do it if you want me to go through how I think, I can't say that this would always work, but I gave a talk recently to a group and I'm saying the one way we do it is a nice break it down. How would you, how would you explain risk if you go to NCOR the National Council of Osteopathic Research? There are figures there that you can look them up and it tells you, gives you ideas that can say one, one in six hundred thousand, one in a million. I had recently a, um, a, a, a CT scan, carry it out and the person said to me, uh, especially said to me, well, uh, um, when there's one in 15,000 risk of, of us causing some damage here, but if the risk aren't as good as the results because we have this nice image of you. So I said, well, surely you should, want me more stronger. And no no that's the view of a specialist at a hospital I went to. Here, we've got the risk so slight it gets ridiculous. One in 600,00 1 in a million and I, I'm not sure if there's any

APM: Those statistics have to be qualified further don't they that incorporates everyone who's doing a cervical manipulation is not necessarily those who are highly trained to do.

Paul: well done. That's exactly right. Therefore that you become even worst. There's a very good book. I'm recommending people to read called risk Savvy S A double V Y you can put it on a website that my son got his he's a banker and it would give all the bankers about risk in finance, but it was so this is good. It also had a section on Doctors and I saw a Dr recently he said, oh Gerd Gigerenzer And he's very good. He's well you have to read his book. Academic book not the one I'm talking about. And risk can be played around so much. It's people go mad. For example, off the subject, sorry I've I it talked about, but after 9/11 people who stopped going by planes and start to go in cars, but there are many more car accidents then plane accidents. So people started reverting back to people react wrongly. So therefore the information of one in six hundred thousand, one in a million, maybe it's not the best idea, there are different diagrams. The one way of explaining it is. For example, sneezing. You have the same result. You could have a cervical a dissection carotid dissection for sneezing. You could, if you're a lady, you, you put your head back. We all know this. You can have it when you're washing your hair being washed at the Barbers, it's so slight. But the question is all very clever saying this and your, your, your, your viewers will probably say, well that doesn't help us get down to the gritty.

APM: What, what, what's the gossip of this matter? My view is that you should, um, but it won't. You can't quote Paul Grant that will get you off. I'm just saying think, think if informed consent means talking to your patient, gaging what the kind of patient is. Do they understand it and all these other things. But so far as that particular regulation I say tell the patient At the beginning

this is what I'm going to do. I've now diagnosed you. I've now worked out. I'm now going to start my treatment. What I intend to do is soft tissue go into all that and there will come a point when I think I might manipulate you now manipulation means x, y, z, and what I might do, I might do a manipulation where I understand it on your neck because I do think it's, it's indicator you should do so I should tell you there is a risk involved that to tell you about it and it's one in 600,001, depends on different statistics is very, very slight indeed and they could result in a stroke. But let me tell you this, is that uh, the statistics are such that the risk is minimal, but I've got to tell you about this. I just want to tell you about it. So you're aware of it. Just they can always stop me, you know, use your fingers and when you get into it you said I'm going to do a cervical manipulation. You do recall what I said before about the risk. Are you content with me to go ahead doing a straw poll and his face statistics based on a very wide range of people, not having too many osteopaths that people tell me if you do in that particular way and intelligent way that anyone it's about ninety nine percent will let you go ahead. Go ahead it's the way you say it.

APM: we did have a very interesting discussion years ago about informed consent with a lady called Pippa from the London's of university. Um, and she was saying that you've, if you've explained statistics to people, they don't always anticipate. They don't always understand them the way you expect. So if I turn to you again Jo, if I say to you the risk of an adverse reaction, serious adverse reactions were cervical manipulation is one of the six hundred thousand. Are you happy for me to go ahead? How do you feel about that

Jo: Well you said it to me in 2010

APM: Um, phew.

Jo: I remember it

APM: Right. But were you able to process that? And give an informed consent. I presume you did at the time. But um,

Jo: yeah, I think like what Paul was saying about saying at the start and then when you come to it later on saying, are you OK for me to do it? That gives some more time to process what that means rather than going, OK, that's fine. Yeah, you can do that. When you've been made aware of it, if you're going through treatment, you don't tend to jump straight into that kind of technique? So I guess by that point you've had a chance to think about it and gage how well you're being handled for other treatments to then go OK. Well actually, yeah, I think um, I feel comfortable you doing that because so far it's been OK. That's an easy way to I think

APM: you personally handle statistics well. So one in six hundred thousand means something to you, that may not always be the case with any patient because some people prefer to see a little red dot in a great big circle. And let's put that as an indication of probability.

Paul: I was going to say that exactly. This is the Gerd Gigerenzer book as well as other publications is if you show a diagram to somebody and you have those little dots like not emojis but whatever. They call it something else, and then there's that one little smallish dot in a million. Then people would understand it much better visual because you talk about visual. Visual is also a good way of doing it.

Jo: Or, in relating it to like populations of towns or cities or something you could say within this country there's this many people and try and liken it in that kind of respect. It gives a more of a concrete way to look at. Guess you could say people that live in Birmingham for example, I don't know how many do, but it kind of gives you a scale to look at

APM: Paul, what are the statistics for serious adverse consequences to a cervical manipulation amongst the population of UK? Osteopaths.

Paul: I've. OK, the, the, the prop. OK. I like to answer the question, but I'm going to a skirt around it for just a second to explain. My difficulty is there could be a number that could be. I could say to you 10, 20, 30, forty bearing in mind that six million, six thousand or six thousand last year,

APM: five thousand osteopaths

Paul: um, but, but the point is that unfortunately you don't know I was on NCOR on a panel, uh, looking into risk, et cetera of number of years ago. And the problem is, is that the insurance companies will suppress the information because what happens is purposely because what happens is, is that you bring a claim and the, the, this is a clinical negligence claim rather than a disciplinary case, although it could affect the disciplinary case, to deal with this process, but somebody wants damages because their necks been injured as you say, but the problem you bring the claim it goes to the insurance company are acting for the osteopath and they will pay up and therefore you never know that you can't actually get a base of information. So far as my personal knowledge is concerned, I think as far as I know in the last twenty years, it could be just maybe one or two. I haven't. That's only me personally as an individual and there may be others that you just don't hear about it.

APM: Right. But those are the ones that are actually gone to the disciplinary committee or to

Paul: gone to court.

APM: And what were the two? Do you recall? What were the, what were the adverse consequences of those?

Paul: Well the adverse consequences was a large payout of money

APM: Well that was the adverse consequence of the practitioner what about the patient? What were they claiming was the damage?

Paul: Well, they're claiming obviously some kind of a stroke

APM: Something serious.

Paul: Yeah so a stroke. while the other one's patients have complained, uh, my most recent, another reason the case, my was was fascinating, uh, it was, uh, the, the, the final day was today as it happens and he ended up with the admonition and he was, he was, he was a gentleman who was both a chiropractor, osteopath, I won't give you other names. So the numbers round. A very able. Very good communicator, very nice man. And um, he took the view that the risk was so small. This is quite unfortunate. He took the view that the risk was so, so small of a cervical manipulation. They explained everything to the patient that there was no need to do so the result was that the case, a case came against him, not because of this, but the patient complained about something else, but in the investigation by the GOsC said they asked the question, well, when they did manipulation, did you get consent? Oh No. The patients said, and then therefore that allocation. It wasn't the main point. While the person who brought the complaint to the GOsC so it comes before the PCC, the expert, I found the expert, I've found one or two experts weren't for. You always need to get consent for cervical manipulation, but this particular expert said, you know something, there are a lot of osteopaths who don't get consent I don't think It's necessary. So we were very, very happy about that because it's supported what the client said and the client assisted. I didn't need to. I, I've read lots of books. I've done all this studies, et cetera. Cut a long story short. Um, we had one hearing and then it got adjourned the second hearing. The expert changed his mind and he said, well, you know, although I said so really looking at the ops, I think you probably do need consent. That didn't help us though my client was very young. They say say we went to the hearing and it's finished the patient today. He got an he was found a upc on uneffective proffessional conduct, but he already got away with an admonition, because they recognize he was a very good practitioner, very able, et Cetera, and he said, anyway, that I in future I will always get, will be very careful in getting consent.

APM: There was a really, really important point in that isn't there that you may be on the wrong end of a complaint, which has nothing to do with informed consent, but when your notes are read the professional account, professional conduct committee, if they see you haven't been getting or recording informed consent, then you might well be taken to a hearing by them for that reason.

Paul: Well they will do they look at the notes and then they ask the patient, did you get consent? I didn't even think about that. Uh, you know, I don't know what goes on in the conversation. And the GOsC meet with or on the telephone, but yes, that, that, that comes out.

APM: So this is going to take us back to a whole lot of questions around what constitutes consent. Had a really interesting one. Come in and I'm sorry, I don't know Is James from Fife So James, thank you for the question.

Paul: Long way away.

APM: Well we've got patients we've got the viewers in where do we hear France? Um, where, where the others early on there was a lot of people from across the world signing in. But anyway, this one's from Fife. James. As long as I gain consent from the patient, Can I make an audio recording of the whole session, which would solve a lot of problems. Consent asked for and given could be recorded, accurately.

Paul: Thats a lovely question. They are the in fact that leads you onto the fact that we are so vulnerable because they will be in a room alone. If there's no chaperone and an audio recording. It seems to me that If you've got well actually I see no reason why not, because if the patient consent back to consent, the patient realize is there are, they consent a consented to the audio to consent to the, to the treatment. So if the patient is fully aware and has no learning difficulty, I don't see why not. I think it's very unusual to have that done, but certainly the opposite is you can't CCTV. You cannot audio without that patient's consent. Certainly an audio. If the patient consents. I see no reason why not talking about English law, Scottish law don't now, but I think it's the similar to

APM: Sorry you mentioned CCTV there I don't know anyone who has that in their treatment rooms,

Paul: but the one osteopath said I'm going to put one up I said, don't you dare.

APM: Well there was a case recently of an osteopath with concealed cameras in a treatment room wasn't there, and um, that went to court not to disciplinaries

Paul: I heard one with a pen and some nasty sexual things went on but I won't discuss that.

APM: Are we best to seek consent technique by technique or by treatment session. I tend to write an abbreviation of benefits, risks, and alternatives, the bra acronym that we're often taught, a treatment plan discussed and agreed before I started treating and will often, but not always add a specific note next to some specific technique if applicable. For example, C spine HVT

Paul: Well, the answer sorry there's a number of number of points in there I think, but as far as I can see it, but the point is the consent is the is the touching. The consent is to avoid a certain battery and therefore if you've got the general consent, your in quotes OK as long as you've gone from the formula, et cetera and so forth where the major consent one is manipulation and injury there by. So if you. If you've. If you've got the implied consent and I'm going to treat your back, I'm going to massage your back. I'm going to give you MET whatever with a soft tissue, et Cetera, but you don't have to each time. I do think that it doesn't mean that a, but it doesn't mean I touched you. I touch your shoulder I touch your leg. You don't think the consent, but you should say, I'm going to now move to your head. I'm not going to move to your shoulder, et Cetera, et cetera. I think you should know anyway,

APM: if you have given the overall briefing. Jo Recalls from the first appointment back in our, my clinic. And so you've given the patient the, um, the, the possible adverse conference for consequences, the likely benefits of treatment when you get to the stage having completed a subsequent examination. You say, I like to manipulate your back now. Is that OK? Is that all right? What do I have to say? Remember I told you earlier on

Paul: we should, I think you should add. You remember I did tell you what's involved and I told you the rest involved, so make sure they are aware of it. The point is, is, is when you're treating that patient, you're holding that patient there. By the way, the risks are I can take. I can pull your head off. I could, I could cause you shock you got were also. Now the idea is you tell them in advance, but given a sufficient to a warning, but I said to you, there's nothing a pain-free here or insurance free for claim free because the patient will say, well, I forgot it. I didn't know he didn't make it clear to me. So all we can do the very best that we can possibly do. And that's why you're notes are so, so, so important to write it down.

APM: The point is, I'm just about to read the point I'm just about to read, um, brings that out, but it's slightly tongue in cheek. But actually it's a concern of so many practitioners because whoever sent this in. I can see a Cathesc point in the future were to be highly safe in regards to not being sued. We spent so much time talking and explaining and handwriting, but we've got no time for treatments.

Paul: Actually, having said that, I come from a family of osteopaths. My father, um, qualified in 1948 and the Bso he used to teach there, et Cetera is I do think that we do have to talk more and I think a lot of psychology involved in it, I think a lot of osteopaths go for a course on psychology or CBT, et Cetera, and so forth, and say, well, the other thing I say, unlike many osteopath, unfortunately we are my family is there the about four or five osteopaths including my father, my late father is that we did spend an hour with the patient my father may have spent two hours some days and then it's very non money making and it's not on the fact that they did spend a little time speaking, explained a Cetera, et cetera. So well I mean the patient if you give five minutes to your patient, you're gonna have problems because I always quotes in any talks I give is there's a, there's a book bought out by um, uh, a book about, um, risk etcetera. Another I'm thinking of is Gladwin I've got the name now, but anyway, he read a book. I need to just stick walls again this, in America, doctors who were not sued, the the weren't so good who were not sued, those spent twenty or twenty five minutes with the patient, the doctor and spend five or ten minutes or more likely to be sued because they didn't give enough time as, as as Jo said, is they didn't explain things or they, the patient didnt feel comfortable with them or they come in, sit down the paternalistic approach, whack, whack, whack.

APM: The, the hostile patients straight away.

Paul: Yeah.

APM: Of course. I'm quite openly Laurie, Laurie Hartman, will admits to treating 34 patients in a day with fifteen minutes per treatment wondering what to do with the last ten minutes.

Paul: It's Malcolm Gladwell by the way, was blink. Probably. That's where it came from that.

APM: which it only we'll put the references on the website. A question for you Jo, if I may, uh, because you talked about eye contact earlier on and how you hear better if you're not making eye contact. This question is, do you have any advice for us about eye contact? Should we avoid it as well? Is it threatening or was it OK just for you to avoid our eye contact?

Jo: Personally, if I'm not looking at you. I don't really know that you're trying to make eye contact, but I guess if you're kind of going like, like that, that might be uncomfortable. Um, someone, um, I don't know if. I don't know how other people pick up social cues because I don't pick them up very well, but um, if you can notice that someone is avoiding that gaze. I think if you're trying to then force that gaze that that might be uncomfortable. So I guess that would be my thoughts on that.

APM: Um, another one for you here, and I don't know who's asked this question, but whoever it is says, I hope this isn't insensitive, but could you tell us to whether you might be happier holding the fidget thing while having treatment? Please, could you also thank her you for coming in on the show it's interesting and helpful to hear things like this from someone who actually experiences the issues we're discussing. Well of course I was going to thank you later on because I think he's a major achievement to get you in and talking to people like this, but the question there is, would you be happier holding your fidget toy while you're being treated?

Jo: Um, on occasion, like chewy things as well. That can be good. So when I'm stressed I went through a phase of biting myself when I was stressed and anxious and actually in appointment more with NHS professionals I've come out with bite marks on my arms from the stress of the appointment and how they've been dealing with it. So stuff like that, having that out and knowing that that's acceptable, um, would be helpful. Cause I think, um, for me like growing up without the diagnosis has been about learning that I can do things differently if it helps me. So knowing that it's OK to do things differently and it's permitted, I'm also kind of helps

APM: going back to you again, Paul if I may because I'm taking these questions as they come to me on my list. If a patient makes a complaint, are we in our defense allowed to highlight that the patient was or is difficult, disingenuous, etc. Or perhaps has mental health issues. DO we need to write our suspicions to our notes at the time?

Paul: Yeah. The answer is your notes are your savior and obviously they're not offensive notes there, there, there they're, they're are notes what I've seen in the past saying, uh, for instance this patients, a lunatic or this patient is a mental case when that person was drunk, really drunk when they had a

stroke. it, you should be very careful what you write. But the fact is certainly at the very great question I congratulate that question, cause that's something I should, uh, that, that your, your, your, uh, a person they are because of the fact that the notes are to repeat myself are very important. Because if for arguments sake, the complaint comes in the telephone company making a note of even the telephone call and pay the patient rights in rings in what have you make a note. I explained to the patient they shouldn't be concerned and so forth. So it should be written record so In other words, what I'm trying to say is the notes are not only for the treatment itself, but also for the sequel. If a patient complains that you rush all down there,A it's an aid memoir and B remember its contemporaneous. So if when we get to the hearing, there's a dissonance between what you say, what the patient says you, you have to. You'll have your notes there which usually are accepted as a true note of the particular date

APM: Um Jo, Monica has asked where we can buy those fans and I think we'll put that up on the website afterwards. But actually I was thinking the same thing, that it would be useful to have something like that available just in case

Jo: these ones are made by the play doctors. So there's a website, www.theplaydoctors.co.uk, but you can get things like that on amazon. And um, different kinds of websites. So sensory toys or communication aids for autism in google when you come up with loads of stuff,

APM: we'll, we'll put that up a bit later on on website. Somebody has mentioned, commented that surely the risk of arterial dissection is greater with twenty minutes message always traction, traction or articulation rather than with a well performed a low velocity thrust. Do we have to say explain the same risk of cva for any neck treatment? And if I can develop that question, of course, if You go on one of laurie hartman's minimum leverage courses, then you are taught a completely different method of art, cervical manipulation. Then you might be on, well I'm not going to name professions or practitioners, but those courses where you have long leave a high amplitude manipulations. So the question here is do we have to really get the same risk assessment for everyone even though we're doing things differently? Was I clear?

Paul: I must just. I've never been asked that question before. It's a new one for me, but it seems to me that again, it depends on the statistics. If the statistics say that for cervical manipulation does involve this one in six hundred thousand You've gotta, you've gotta, you've gotta give it just in case you're the unlucky one. You haven't given that warning and something does happen because remember, cause the other point should I should add to that is when you are giving, you must always give alternatives. As you know. You can't merely say this is the only way of dealing it. you can say I'm going to give this treatment, but they're other ways PRT I learnt in my day with any, what we call it nowadays, positional release technique. You know, you don't the other way to release it. So you always gotta to give the patient the alternative as well. Just say that's not the only the only way to deal with it.

APM: If I can put my own perspective on here as the lead witness, Um in my own clinic where I start out as Jo has mentioned earlier on by giving an outline or the risks of the different types of treatment, including just the general soreness which people might suffer. Um, and I try to put the statistics for serious problems with arterial dissection or whatever in perspective, but I also say to people that most of the practitioners in my own clinic have been trained to a very high standard in cervical manipulation. And as an osteopath or chiropractor, that's your starting point. Of course, if you've been on Laurie hartman's course or similar course by other practitioners to learn minimal leverage techniques. What I'm basically trying to do is to say, you know, there is, there is manipulation and as manipulation and we're a lot better at it than the statistics might imply and some of us are even better still. And Paul would probably smack me for saying that. I think that's a better warning to others. But so at least it's, it's trying to make them more confident about what we do. I think

Paul: It is. the concern i have talking to young osteopaths I was brought up by my father it's one of our things we osteopaths do manipulation and I'm concerned, that we're so pushing it about it, so worried about it that you'll find people that are going to not do manipulation, which is part of our are very structured. And it's quite worrying actually. I think people should, should, should read up, learn, et cetera. And carry on, manipulating because that's what we are to and plus other things. We do.

APM: Paul, I've got more questions than I can hope to cover in the next few minutes, so I'm going to save them up and ask them of you outside the The, the discussion here, but I've got one that's coming from danieli. Again, it's quite a long one and I only mentioned this because the word solicitors spring out of it. This is a big problem these days is the solicitor seem to have started requesting a copy of records or notes. This is obviously to save cost rather than to ask what is usually a more more expensive option, which is a full report, I therefore make a point of intentionally writing my patient's notes in my own shorthand, which they won't understand with a glossary key that I then give them if required. They'll then have to ask me for translation explanation. Then he says he charges the solicitors.

Paul: Ok, right. Well I like this. Daniele. yeah. That wherever, wherever is from.

APM: He practices in dundee, italian, italian name for I think an english born osteopath, but now lives in scotland and has a scottish accent. Might be Glasgow. Daniele. I might have gotten it wrong, but don't write in and correct me. You did that last time and I apologize for all my errors.

Paul: Daniele Lovely Question. Thank you for asking it. I wish I knew the answer. No I do know I do have an answer to what was the question again? Yeah, yeah. Right. OK, just very quickly, why do. lawyers do not respect osteopaths This is being a bit coy. I suppose. The fact is that if we have a. Usually the osteopath would want. The lawyer would want to have the notes In order to learn about the patient, but it It could also be they want to sue you, but we don't know why, but remember there's a thing called the data protection act, which will be translated into the OGDR to give it to give

it a new title in the new year which obliges you. You have no choice but to give any data you keep on a patient to a person who applies usually the patient and you can charge up to ten pounds for that information. You can google the ico, which is the, uh, the commissioner who deals with all the data protection and it will tell you so therefore you can charge for your notes. Ten pounds, no more, no less. That's how you charge less than ten pounds, no charge. So that's where we are.

APM: But you don't have to translate it it can be your short hand.

Paul: They could exactly right. However, however, for my purpose, I think that's unsafe to do so because they look at it misinterpret it. You might get another letter and you may want to ignore it, but then they start saying, we're going to sue you we're going to do x, y, z. unless you do, because we think you might have done something wrong. My view is however annoying it is is to say to them, here are my notes and here is a transcribed version. I know it takes more time, but it may be your saving grace because you might realize when you're starting to try and throw them, Oh my god, I forgot to put this in or I forgot to do this or something else that reminds you

APM: one last question I promise for this evening again, I don't know who this questionner is. I used to use consent forms that I prepared with references which cover general treatment, side effects and mainly HVT and possible side effects including severe side effects I was told that even if patients had signed the form, it wouldn't stand up in court. What would?

Paul: The answer is it wouldn't stand up in court, but it wouldn't necessarily fall down in court by which I mean at least it shows the. The fact is it's evidence. If a judge, hears a case he hears the issue. Whatever it is, the evidence, the evidence is one person say A another saying B and the judge has to decide what the facts are, so therefore the patient said I didn't get consent. The osteopath I did get consent. The judge will then say, well, any witnesses and there's nobody else around there, and the judge that the patient that then the osteopath produces, his notes and the notes show, this is what I. This is why I always do this is this is my, is this all helps? well, I tell my clients, if you have this regular or people I train, I said, this is what you usually do. This proves it's all written down there. Say so. I will. If I'm the lawyer representing the osteopath or wherever, I would say, look, the logic is the patient had two years ago, what are the patient? Maybe the patient was worried, et cetera, upset, et cetera, but here we have a normal situation. I call other patients who will say, yes, Paul Grant always does give this going to explain it helps to build up, so I say it won't necessarily win the case, but you'll get a long way in helping you with the case.

APM: Thank you. Paul it's been a very illuminating evening. Thank you very much it's very kind of you to come in and share your wisdom here I hope you won't mind answering the other questions.

Paul: No no thank you Thank you for your, for your, your viewers because it's interesting. The questions that come up.

APM: It's such an important topic for us. These days isn't it?

Paul: Certainly in Jo. Jo's as well marvelous

APM: Yeah Jo I'm really, really grateful for you to come in here. I know it's a long haul for you to get down here and I imagine it's more stressful than I can imagine to sit under our bright lights and face an unknown audience with unknown questions, but it's been really helpful for us, so thank you very much indeed. I hope of course that you have found that just as helpful as I certainly have.