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Communication and Consent - Draft Transcript - Ref 155STSH

with Sarah Tribe and Sandra Harding

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TRANSCRIPT

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

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

Steven Bruce
Yeah, please do? Yeah.

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

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

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

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

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

Sandra Harding
I think the thing that's that when you look at a respect in which the clinical profession is there's some real key themes coming out from whether it be as you said, whether it's quality statement eight from the Royal College of chiropractors, whether it's principal, whether it's the quality assurance standards for physios, whether it's the hcpc standards of proficiency aspect, whether it's the May, the thing that's coming out from all of them is that that communication, and that patient partnership is absolutely key. And I think the thing that way, it is really important this so many complaints are driven by poor communication or issues around

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

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

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

patient understanding. So that can generate your complaints, which obviously, then can, you know, there's a whole communication piece that said, we'll come on to when she talks about consent about explaining what you're doing. And there's instances with the hcpc, where patients didn't expect what came because they haven't had a full communicate, they know the communication wasn't very good. One of the things that Sarah and I always say is never take a patient by surprise, make sure you've communicated in such a way that they understand what is coming, because taking a patient by surprise is often a route to some things that you see coming up and being reviewed by the professional registration committee.

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

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

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

I think it's

Sandra Harding
on, I think it's league would probably would probably bring up an awful lot of politics. I'd imagine we've got some people jumping around in their chairs watching the screens at the moment. I think we've got to be

very careful. I would agree with you. Otherwise, I think we will be going off on a tangent down here. We're talking about informed consent to the vaccine passport. Sarah, I'm not sure what you think on that.

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

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

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

Steven Bruce
that's all very well. And I like to think that we all do that. But the big issue is about recording consent. And most of them this question will come in, if I don't raise it. Now I know. If someone comes into me, and I want them to undress, and I want to touch them to do some passive examination, and I want to do some soft tissue work, and I want to do some, I don't know, some hivelocity techniques or something else? And then or maybe some provocative tests. Sure, I'm going to tell them what I'm going, what I'm going to do.

And I'm gonna say, is that all right with you? And they'll say yes, generally. But if I have to write this down in my notes every single time I've done something that's a bit long winded.

Sarah Tribe
Well, if you if you write down VCO, verbal consent obtained, okay, that signifies that you discussed throughout the treatment session, how the treatment may progress and allow the patient the opportunity to discuss matters with you. And you need to record the key points raised in your clinical notes. So you just need, you don't need to be keep biting down Vizio Vizio Vizio, you just need to do it once. And that covers you, then you need to have an informed consent policy as well to back to back it up. But that then signifies that you have discussed the risks and the benefits with them and the complications and give them an opportunity to say no, but it's so it's it's about having in the back of your mind, about what what you're actually asking them for. And it's not a case about writing everything down. It's just about key points.

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

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

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

Sarah Tribe
Well, it's going to be a patient saying I didn't agree to that form of treatment. Okay. So it's about making sure that you have done everything within your power to the regulations and standard to make sure that you have tried to explain to that patient exactly what's going to happen. For next up, for example, there was a

complaint. I don't know whether you saw Do you want to come in with this one about the straight leg raise? Yeah,

Sandra Harding
I can raise I can bring this up? Yes. An instance when I brought a legal expert to come and talk to the team that I was managing at the time. And I asked them could they bring an incident that had happened with a healthcare professional with patients something they'd looked into, and this patient had actually gone to a solicitor to seek advice regarding assault, because they come for treatment. And the therapist had done a straight leg raise on them. They said they felt very vulnerable, their legs were in the air, they were in their underwear, and they didn't get the chance to say no. And the solicitor said it could have been D, it could be deemed to be assault, because that conversation hadn't happened. Now we all know a straight leg raise was a testing procedure that's often used as his hip abduction. But then the message that the legal person very clearly gave was, you gave that patient a surprise, they didn't know, you didn't tell them what was happening, they didn't have the opportunity. And so you've got to make sure that you're talking through as you're doing it, because by saying that you've obtained their consent means you're having the conversation service that you're sharing it with them, you're giving them the chance to say no, and then know what is happening. The patient said, when they left, they're in a state of shock. And they felt violated.

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

Sandra Harding
Before the feedback, Stephen was we should what should have happened, he should have explained as we were talking and just Are you comfortable that I do this, I'm going to take your leg up into the unit, etc. Just talking as you're doing and giving them the chance to stop. But to be fair, your responses exactly the same as most of the room that was there that day, we will also you don't do that. But he did say he came with a case as we asked him to break. And that's what he brought to us.

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

Sarah Tribe
So an informed consent policy is actually very detailed. And it goes into why it's important to gain informed consent, it will also talk about Montgomery versus lecture hellspawn 2015 case, moving from the montgomery to that from the bolam test and the Montgomery test. So you understand what the bolam test was what what this is what this reasonable practitioner would provide. the montgomery standard would which is what this is what the patient wants to know. So it's really important that you understand that change in legislation. So that there is because Montgomerie, I'm sure you know that this was a lady who delivered her son vaginally, and she was a small, a small stature and diabetic and the her son was was was a big baby, and they didn't they dislocated the shoulder to get the baby out. And he then had hypoxia and ended up with cerebral palsy. And the lady got pursued and won because the risks and complications had not been discussed with her. And if they had she said she would have opted versus arion. So it's really important that you tell the patient, everything that they need to know, not just what you think they need to know, the case. So so your informed consent policy has to go through all of that has to do to know you have to know what capacity is you have to make sure your patients have capacity. What does that mean? What's the three stage test? Okay, you need to understand what capacity is and what 1617 year olds can what they can and can't consent for. So there's a whole piece that needs to be written down. So there is your evidence that you've got, I've got this policy, I really understand the Montgomery the bolam, the capacity, all of those things. I get verbal consent from my patients, they have a patient information leaflet, they know what's what to expect that they will be expected to buy the dress and that they can have a chaperone if they wish to. So it's all about thinking about sort of really sort of Belton braces so that no patient is taken by surprise and so this policy is not a dry, dusty thing that sits on a shelf that you think oh god there it is. You know it's about a living document. This is really under my These are your foundations in your kitchen. This is really getting your kitchen into the shape that it should They. So it's important to have a policy. And it's important to understand what verbal consent obtained actually means.

Steven Bruce
You say it's not a dry and dusty document, I suspect that people are thinking, God, I don't want to have to look through the findings of bolam and Montgomery, because and we can summarise those findings for them, because it's relatively straightforward. But nonetheless, they'll say, Okay, I've got to put this together, it will sit on the shelf, and it won't get looked at for another six or 12 months, except in the instance in the case that I'm taking before the Professional Conduct committee, in which case, I can guarantee I will no longer Murray inside out by the time I'm in front of that committee. You know, and again, I'm saying I don't think this ought to be a paper exercise. But we've had a question from Carrie, who says, you know, at what point does all the paperwork become overwhelming. And she says, between sending out information about what will happen GDPR, and she sends out information about COVID procedures and the risks of face to face appointment, he does a lot of paperwork before they've even met you. And I wonder too, and Sandra has maybe one for you, there is so much going out now that maybe people are inclined just to tick boxes, because they're gonna come to bother to read it all.

Sandra Harding

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

Steven Bruce
Probably my TV is going to shut down in 55 seconds, do you to sleep or press any button or Bernie just in this a better word? There we go.

Sandra Harding
There you go. We're back. Again,

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

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

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

Sandra Harding
I mean, obviously, Sarah, and I have a template that we use, and various trust, things have templates, they're all very, they're all very similar. But the important thing is that you're covering the key themes, which is, you

know, how do you do the version control? Where are the references? Who is the document for who needs to sign up to it? What is your process, you know, what are you relating to, but once you've got that, and you've developed that, then you can replicate that across all parts of your business. So that you've you know, once you've got your template, you understand it and it works for you, then you can drop all your different policies that you need to place into that template.

Steven Bruce
So wherever they get the template,

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

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

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

Steven Bruce
How old was how old was Victoria gimixz daughter?

Sarah Tribe
How old was she? Sandra,

Sandra Harding
I wish you

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

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

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

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

But clearly, I

Steven Bruce
should.

Sarah Tribe
Yeah, yeah. Yeah.

Steven Bruce
Gosh, someone else has just sent. I was trying. I was trying to ask this question a second ago, Sam. Thank you, Sam, you talk about a three stage competency test? A little while ago, you mentioned it. Sarah, could you elaborate?

Sarah Tribe
Yes. So there's, there is a three stage for capacity, there is a three stage test. So the three stage informed consent, informed consent has to meet three tests. One, the capacity to give consent to consent must be given voluntarily. And three, the patient must be given all the information they asked for in order to make

their decision. So if you decide if somebody is has capacity or not, again, you need to decide on again, there's the three tests. So there needs to need to be able to understand what you're saying, retain the information, and weigh it up and make a decision. So as long as they can do all those three things, they have capacity, if they fail on one of them, then they don't have capacity. And then you have to make a best interest decision.

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

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

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

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

Steven Bruce
So, whoever treated Gwyneth Paltrow should have warned her that the company would leave those big marks on her back when she was about to appear on the red carpet somewhere. Yeah. You? Yes, um, you said something there, which which intrigued me again, about, you said you had to give all the information, which sounds to me like we're getting into informed consent as opposed to valid consent. As everybody

knows me, there's, there's no in the amount of information you could give about most interventions. And also, people will ask me, Well, actually, not every manipulation could possibly result in death. If I if I manipulate your elbow, I suspect there was absolutely no chance of killing you whatsoever, might frighten you if I didn't warn you about it.

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

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

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

Sandra Harding
we were just talking about this third night early today, this exact book.

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

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

Steven Bruce
with someone earlier today do the sound like a Nick Hornby novel now the top five. So what were what were the top five that came out?

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

Sarah Tribe
loan working loan working. Yeah,

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

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

Sarah Tribe
it? If they are the person, it has to be the deemed person. It has to be illegal. I know it sounds mad, and it does. It is mad isn't it sounded when we were talking about it, but it has to be the birth. Father, the biological birth father who was allowed to give consent.

Sandra Harding
Lee is illegal. It's not a certain standard thing. It is. It is literally it's legally in there. Interestingly, why? I'm not quite sure on as was the Sara said, Yeah, we're not sure why, but it is it is still there. Who's listed that?

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

Sarah Tribe
Yes, it will. It's a bit like, if you do a best interest decision, it has to be the person that has the power of attorney for health and health and well being is the person that can help decide in in best interests. And it's

the same with giving consent, it has to be the person who has the legal who is legally has taken legal parental responsibility.

Steven Bruce
Right. Okay. Thank you. Kate has asked if a grandparent or sister brings a child in could they give consent in place with the parent?

No,

Sandra Harding
we're ready. One of the things that we we've discussed, Stephen, that people might find interesting is that a case that came up that we were discussing with some professionals was they said they regularly found that the school drop the children off and left them for the treatment. And we were talking through this whole age, the you know, the under 30s. And then they 13 to 16 year olds, and really making sure that you've got the right consent for those children. And the people don't just assume, oh, we can leave them they've seen you before. So it's fine. Now they're not a new patient. So we're saying, you know, you've got we've got to make sure that the process of consent is very clear from the beginning. And if someone brings a child that they're aware what that process is.

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

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

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

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

Steven Bruce

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

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

Steven Bruce
No? Okay. All right. Alistair says if we're constantly getting verbal consent, if there's a problem, then surely it becomes a he said she said scenario, which I suppose is what actually happens when you're in front of the professional conductors. And

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

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

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

Sandra Harding

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

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

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

Sarah Tribe
Yeah, no, that's Yeah, that is that. So it's all about communication, right at the start about who needs to be there and who needs to be with the child, but also assessing whether the child has get it competent, in which case they can give consent themselves?

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

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

Steven Bruce
Yes. And it's worth bearing in mind, I guess that lots of practitioner patient relationships, which start out Well, can easily turn sour if there's an adverse outcome of some sort. So if the child went away, and something had gone wrong, at least in the child's opinion, if not, actually then the parent might turn on the

practitioner. Ellie says, Can you not just tell the patient what you're going to do? And then stick on? Is that all right on the end? Sarah?

Sarah Tribe
Well, if it's about an ongoing process, it is about saying as as you're going along, is it okay, if I, so you are saying those words? It's not about it's about all the time about this? What is what we do anyway, is what we do as therapists, we talk to our patients, we say, Is it okay? If you get on the bed? Is it okay? If I was going to lift your arm up? You're doing it all the time, so that you're gaining informed consent as you go along?

Steven Bruce
Yes, but earlier on one of your three elements of capacity of consent were that they had to you had to be sure that they had understood all the information and retained it. So just saying is that okay, doesn't satisfy that test? No.

Sarah Tribe
So you would have you on your assessment, when you're assessing or when you're seeing your patient, you will have done an assessment about capacity, you will have done that three stage test. Right. Okay. Well, you've gone any further.

Steven Bruce
Yeah. And having done that assessment for a single inquiry, then that's okay. You know, they've got capacity. So you don't have to go through all three stages on everything that you get concerned for. Right, because there is some very nice comments in here about communication. Aiden says his favourite quote from his mentor University is never miss a good opportunity to shut up. He takes that as a general rule, not just specific to him, which is fair, and Fiona says consent.

Sandra Harding
Do we use a mouth doesn't it that much is that comment

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

Sandra Harding
Which goes back to the communication piece, doesn't it? Where we talked about trust? And I think, you know, thinking about that trust as well. It's also about the words that we use, you know, do we use words that motivate and encourage our patient? Or do we use words that don't you know, how many times have we heard, and I hold our hands up with a professional say, your back wears out as you're getting older, that's

really not helping and giving a positive outlook. And it's completely different, you know, to say that the scan changes, yet they do change, you things do change, as you get older, it's like getting greater grey hair, but it doesn't mean there aren't things that we can still do. And it's that, that's that messaging. And then Deborah uses a nice analogy, where she says, Does our communication make our patients with a, you know, a condition that they're probably going to have for a while? Does it make them feel as though they're driving and reconditioned and it reaches a really nice photograph of a camper van? Or does it make them feel like they're a scrapper, and they're on the scrapheap and they're falling apart. And I think it's this whole piece is so beautifully entwined in the way we communicate, the way we get across the way we motivate. And the whole consent piece, I think is so beautifully wrapped up in the way we deliver that message and the you know, the trust and the way that we move forward with that patient and understand them.

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

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

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

Sarah Tribe
Well, the thing is that if you've got uniform consent policy that will cover all your capacity, so that you so therefore, if you've got VCO written down that is covered that you know about capacity, and you would like to test

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

Sarah Tribe
three step tape for folk about to assess whether somebody has capacity. First of all, you need to make sure that they have understood what you've told them, that they can retain the information. And they can weigh up the information to make a decision.

Steven Bruce
So we've just established in fact that Alistair doesn't have capacity because he couldn't retain the information. Could you just give me Talk me through that as though I'm a patient, I come into your

practice, how what are you going to say to establish that I have capacity? Obviously, first appearances don't count, because you'd immediately assume I didn't? Well,

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

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

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

Sandra Harding
Is the key piece about listening at the beginning. And that bit that we said when we started today, steam that when you listen at the beginning, you know, really making sure you've summarised, you've paraphrase the fed back and you feel they do understand, and then you've made

Steven Bruce

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

Sarah Tribe
You're really going to do this with people that you have a suspicion that they do. Yes,

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

Sandra Harding
You can you can, you can determine I mean, if we use the example, but let's go back to what Deborah uses. Because we talked about her earlier and how she uses risks in there. She does that. She says she has statistics, so she can quote some of the statistics so people can make that informed decision. So she uses that in her script. And I think you can say you can talk about your lived experience. This is what you know, these are the statistics. But this is what I found. But it's having that conversation. That's key. It's making sure people have been made aware if there are risks, and that they've been able to say actually, in that case, I don't want to proceed, because that's the bit that will be challenged. Did you explain the risks? Did you give someone the opportunity to say no?

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

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

Steven Bruce
Right? Okay. Jody's just sent in an observation that he or she is a paramedic as well as an osteopath and that their remit is pretty much as you described, for checking capacities whether the patient can understand retain and then relay information back to you. So probably I'm not surprised that you know, capacity and

consent are pretty much the same across all the medical professions only because when he goes to court barristers are going to be the same thing.

Sandra Harding
Yeah, it's okay for the same act in the beginning. Yes, all the framework started from the same place.

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

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

Sarah Tribe
They suppose they specify the osteopathy that specifies about vaginal or rectal.

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

Sarah Tribe
yeah. So but it is, it is a it is an anomaly because within we have women's health with us, we have a lot of women's health physios who do do a lot of you know, stress incontinence, so, but they don't need to have it sent. So different professions

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

Sarah Tribe

There is no, you can get that you can get into does nothing legally to stop you doing that, but it wouldn't stand up in court. It isn't. It's it's worthless, really. Because all they're consenting to, what are they consenting to, they're signing a piece of paper saying I consent to treatment, but they don't know what the treatment is.

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

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

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

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

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

It's such a such an important part of the treatment, but unless you tell the patient so they can think well I need 30 minutes treatment and then you're going to watch my notes but that that isn't the way that we recommend. It

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

Sandra Harding
Yes, you've got the notes, ensuring you've got that process and what is linked to that process. That's where the density, can you show it's just part of this whole package of consent.

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

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

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

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

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

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

Steven Bruce
Here is what I think is a fairly well established myth, you know, physical professionals, john says is the presence of a patient in front of us not implied consent. We've come for treatment, surely that is consent to treatment.

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

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

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

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

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

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

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

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

Sandra Harding
you'd go to your standard, Stephen and see because as you can see, what we're sharing is what one set of standard says is quite the same as what another standard says. So I think you've got to you'd have to check yours for the actual

Steven Bruce
definition. There is nothing in the standards which explains that there must be must be sadly GRC

Sarah Tribe
Well, does it send written consent if I just tell you this a Briton has sent us a new card in law for treatment under sections of the Mental Health Act, human fertilisation and embryology Act and the human tissue Act, the Department of Health and subsequently the Chartered Society of physiotherapy recommended written

consent for injection therapy, acupuncture, dry needling and performing nerve conduction studies. So that is what we abide by profession. Yeah,

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

Sarah Tribe
capacity can come and go? Yeah, you know, it can come and go. So you know, you make the you make the you do the treatment, when you feel the patient has capacity to consent to that, and then the capacity may go, so it can come and go.

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

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

Sandra Harding
So I think they're I mean saver. Also, I think that if an individual doesn't want the parent to be there, and they've been deemed to be competent than the parent has to be asked to leave the room. So I think you know, you can't hurt you couldn't put a blanket rule there, because then you'd be overriding the rights of the individual who had the capacity to make the decision for the suggestion from Amy was a legally responsible adult. So you could say well, I want to chaperone while I'm teaching while I'm treating you if you want then then we go down another another rabbit Warren, if we have if you want to

go down the rabbit rabbit

Sandra Harding
of chaperones and who can and who can't be a chaperone. Because interestingly, across the web professionals that you're talking to tonight, physios, officetools and chiropractors, there is a differing opinion in the standards about what who can and can't be a chaperone. In physiotherapy, a chaperone has to be someone who has had chaperone training and cannot be a member of the family. Weight Loss the

opposite it's different. So in physio, if you need a chaperone, either as a therapist or as a patient, it's something that has to be discussed early is on the patient leaflet. And arranged in advance, which is quite different are aware to how the osteopaths operate.

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

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

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

Sarah Tribe
yeah, that's right. You document document it?

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

Sarah Tribe
look like thunder was gonna say,

Sandra Harding
shall I share a question around that? And it is, it is tongue in cheek pit. But after this is a real one. And this is a complaint that came to me when I was looking after a team and comes back down to manage an expectation and communication. And you're talking about timings. I had a case where somebody said that 1/10, which was three minutes worth of their half an hour was not hands on treatment. So please, could they have a 1/10 discount on their bill? Because 1/10 of the time wasn't spent treating them. So you're talking about going down to the minutes and what's happening. I've I've literally really spent seeing that one. So classic example of make sure you get the message across at the beginning about treatment isn't just the

the hands on piece, the notes and everything. But I saw the individual who wanted their money, but they're wanting to have their feedback.

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

Sarah Tribe
There was no legal requirement to do.

Steven Bruce
I think that's kind of the response to most questions. I think, if you wanted to do it, you could there's nothing to stop you. Let's face it, you have to make those notes available to patients anyway, if they ask for them, but there's actually no legal requirement for you to do it. And I'm not actually sure. Well, my own experience of me as an osteopath is that the notes are genuinely not ready to be signed by the time the patient leaves the treatment room. So they couldn't do it. And they wouldn't understand my handwriting or abbreviations without a lengthy explanation. So Georgina says, as an associate in practice, I'm presuming I should have my own informed consent policy, even though I'm working under the umbrella of someone else's company, there's a very interesting question, who's,

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

Steven Bruce
Okay, so I guess somebody says, Stephen, my patients would definitely not be able to read my handwriting. I wonder who that was clear. Yeah. So are we talking about signing the notes? I suppose once again, you could argue that actually you're showing willing by getting patients to sign the note is a demonstration of your intent to communicate with them, isn't it even if it's not legally required, but yeah. Wendy has asked about the fever test. a push up, as you mentioned, you know, hip abduction earlier on, it puts the patient in a

an exposed vulnerable position. She always asked if it's okay to do it. But should they sign something for that? Is

Sandra Harding
that would you consider that? Because again, it's part of this whole piece that, you know, if you've got your informed consent policy, if you show this is the way you're operate, this is a conversation you're having this is the way you're assessing capacity, then that's fine. You've got your VCO. So it means that they you know, you've been through all the things that you need to go through before you actually carried out that test.

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

Sandra Harding
apps. Absolutely. And I think the thing is, they're, we're giving you scenarios to help you. But actually, if you think about the process we've gone through, what we're seeing is, when they when the individual steps into your practice or your first other conversation, you set up your communication, you manage the expectation, they've had information about what's coming, so that they know you don't take them by surprise, and you document it. And if you go through that piece, which most people associate do go through, the thing that we find most times is people haven't documented it. And that's often where it falls down. they've they've had the conversation have said, I'm going to be doing this, do you mind this? But they haven't, they haven't got the policy sorted, or it's very old sitting on the shelf and not being reviewed, or they haven't documented it. I think if you've done those pieces, then it's just it is, as we said, it's the belt and braces, this just endorsing what you've been doing. Please don't quit. There is no way around this Not at all.

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

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

Steven Bruce

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

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

Steven Bruce
Yes, yeah. Okay. Do we have an answer to the questions that we're getting? How do we know that we've got informed consent? Well,

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

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

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

Steven Bruce
For chiropractors?

Sandra Harding

I can honestly say, I don't know what to say. I'm not sure Because I haven't looked up interpretation, but I know with the training we've just done with osteopaths to do it's another area where there's a

Steven Bruce
slight difference. Right? Well, I'm astonished you know, as much as you do about what osteopath can do. So we'll let you off not knowing one thing about chiropractic.

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

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

Sandra Harding
I think that what we would say is, it depends what where you go to get the info from your governing body. So if I come back and bring Deborah back in her example, she uses statistics that the osteopathic bodies have shared, and they're the ones that she uses. So I think you knew you'd need to be going back and finding out what are your colleagues? What do you appear to use in what are they quoting? And where do they got it from? So that's where we would say to go and source it. Right? Don't give him an exact answer. I appreciate that. But Sarah, and I catch it out for you the statistics of the risk all of those techniques, obviously.

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

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

Steven Bruce
And if you do a short course on how to type you could have one of the people who's sending me my questions I've just realised they put two names together. It's Fiona Ellis, not Fiona Ellis. And I was thinking,

this is a fionnula that's been spelt in great, Fiona, I apologise, I will speak soundly to my team for putting your first name and surname together. We will send out your details, we're going to put your website up on the screen if it's not there already, so that people can get in touch with you they can get your newsletter, which will give them your updates on what's going on.

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

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

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

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

Yes, yes. Yeah.

Steven Bruce
And that's very kind. I only asked that on here because this is recorded. And so I have your consent for all the risks involved, as far as I'm aware, but that'd be brilliant. Thank you so much for this evening. And

Sarah Tribe
thank you very much indeed.

Steven Bruce
There was one thing I didn't address that came in from one of the viewers, somebody who's saying that as consent and communication is compulsory for osteopaths are all the courses that we can do have equal standard. And of course, you heard from the two ladies that they do run top notch courses in communication consent amongst other things. There is of course new requirements in the osteopathic act for us to do any courses at all and communication and consent. We simply have to have undertaken at least one activity in it of indeterminate length during the three year cycle of our CPD and where Communication and consensus comes is discussed in our broadcasts, you will see it on the certificate afterwards. Which means that when you present them to your peer discussion reviewer at the end of the three years, you'll have loads of stuff which says you have done consent. So you got to pay attention. You got to try and do it and you still have to apply the principles that we discussed this evening. But you don't, you don't physically need to attend a course if you have the time to do it. That said, how better to learn to understand what is required of you