CONSENT REVIEW AND REMINDER

Reminding practitioners of the importance of consent is never a bad idea as part of your overall risk management process in running an aesthetic clinic.

It may be especially pertinent to review this after a prolonged period where treatments have not been possible, and with the distractions of new protocols that you may have to be put into place around safely treating clients along with the physical barriers of any PPE that may need to be worn.

This 15-minute podcast with Liz Bardolph from www.cosmecare.co.uk, who has over 10 years' experience in dealing with medical negligence cases, will remind practitioners of the importance of the consent process in reducing problems associated with client complaints.

To listen to the podcast CLICK HERE:

Or read the transcript below:

Ron Myers:

Hi there. This is Ron Myers and I'm one of the directors of the Consulting Room, and I'm delighted today to introduce Liz Bardolph, who I've known for many years, to discuss a really important topic related to consent and medical negligence. And as we're all hoping that clinics will begin to open again in the near future, it's going to be really important to remind both medical and especially non-medical practitioners of the importance of consent and repeat consent as part of the risk management process of running a clinic or salon.
Liz originally trained as a nurse and has 20 years' experience as a medical aesthetic practitioner with Cosmecare, and Liz is also multi-talented with a master's degree in medical law, and has been an accredited aesthetic civil expert witness for over 10 years, dealing with medical negligence cases in aesthetics.

Ron Myers:

So Liz, welcome and I just wanted to ask you how's it been for you in lockdown?

Liz Bardolph:

Hi. Good morning, Ron. Nice to speak to you. Actually, I've been busier than ever. I've been keeping in touch with my own patients, which I think is terribly important, and I've now got somebody to help me with the marketing, because I'm rubbish at marketing. So we've been sending out a survey to find out what the patients want and we shall be sending out newsletters.

Liz Bardolph:

I'm also building a waiting list in anticipation of when we can open, and I really think that the earliest will be August, but we may have to put that back. But I thought I would put something in the diary so that we've all got something to work towards, and so that I can keep in touch with everybody. So with that, and medical legal work, and my other projects, I haven't had time to sit around thinking, ooh, what should I do next?

Ron Myers:

Yeah, similar for me as well. I've been really busy and it's really great to hear that you are being so proactive, Liz. And I know, it'd be easy for someone like yourself as well to maybe just sit back a little bit and take a rest. But I know how you work as well. You were always very forward thinking and I think businesses like yourselves, I think if you are keeping in touch with people, you are talking to them and you are thinking about how you can better market your business, will come out the other end of this hopefully in better shape than some of the businesses that are just sitting back at this stage and just waiting for lockdown to end.

Ron Myers:

So I do thank you for your time because I know it's scarce. What I wanted to do is kick off with this for a start and look at what do both medical and non-medical practitioners need to consider with regards to the consent process, when we can all get back to work again?

Liz Bardolph:

Really, I think they probably need to consider three questions. Does the patient know about the material risks? Does the particular patient know about the reasonable alternatives? And have I as a practitioner taken reasonable care to ensure that this patient is fully informed? And I think if you go into the consent process with those three questions in mind, I think that will be building blocks for you to build up your consent process. Because quite honestly, the disclosure as risk is the area which is most problematic to all of us really as practitioners.

Ron Myers:

Okay. Well, that's good. Three basic questions that you should have in your mind that you need to kind of come out of that process with some answers to.

Liz Bardolph:

I think so.

Ron Myers:

Brilliant. I think the interesting part as well, that obviously I think is relevant for us to discuss, is talking about the alternatives and how far you should go in talking about the alternatives.

Liz Bardolph:

I think that the alternatives need to be reasonable. I don't think you need to go through chapter and verse through absolutely everything. Remember you're setting up a dialogue with the patient. It's a two-

way discussion. It's not a tick box exercise. So you need to decide and decide with the patient what sort of things that they're looking for. If there's a certain particular treatment that they're going to say no to, because you've got that vibe really, there's no point in going into it, so they must be reasonable alternatives. And of course you must give the risks as well, so that they can make up their mind.

Ron Myers:

That's fine. I suppose when you think about alternatives, that could be, for instance, a surgical alternative versus a nonsurgical, couldn't it? And if they'd said, "I definitely don't want any surgery to correct this issue or problem," probably then you wouldn't necessarily go into that. Would that be right?

Liz Bardolph:

Absolutely right. Yes. Yes. There's no point in bamboozling the patient with information that really he or she really doesn't need.

Ron Myers:

Yeah. Okay. That's great. So how, as a practitioner, do you know if the patient or client has really understood what's been discussed?

Liz Bardolph:

I think you need to get the patient to reflect back to you in their own words, what you've just said to them. That sort of reinforces what you said. And also you as a practitioner will know whether or not the patient has fully understood it. And if the patient hasn't fully understood, then you can fill in the gaps.

Ron Myers:

Okay, that's great. What are the practitioner's responsibilities with regards to answering questions from clients or patients?

Liz Bardolph:

I don't think there's any good expecting a patient just to automatically ask questions, because they don't know what they do not know. So you've really got to lead them into answering questions. The onus is on us as practitioners to find out what the patient wants to know. It's not up to the patient to ask the question. We've got to be proactive, whereas again, it's setting up this discussion and getting to know your patient.

Ron Myers:

So, in other words, really what you're trying to do is to help them become informed about something that quite clearly many people really don't know what, as you said, what they necessarily should be asking about treatments or procedures or solutions.

Liz Bardolph:

Yeah, that's right. And some patients are very well-informed because they've used the internet, but some patients really don't have a clue at all. They've come to you absolutely cold, so you've got a blank

canvas. And of course if you're giving patients a lot of new information, it's very difficult to retain. Some of the words are unusual, some of them may be a bit long. Even if you do try and explain them. Getting a patient to retain new information, as you know yourself, is not easy.

Ron Myers:

Yeah. Yeah. Okay, that's good. So what are the practitioner's responsibilities then with regards to documentation? What should they document and in what format?

Liz Bardolph:

Document record keeping and documentation is all part and parcel of the consent process. I think the practitioner must recall the details of the consent process, including the risks and the options that are being discussed in the clinical notes, because lawyers will be looking for evidence. There has been a meaningful dialogue and it hasn't been a tick box exercise, so you've actually written down what you've said. That would help enormously should things go sour and should litigation ensue.

Ron Myers:

Okay, great. Well, that's good advice. So basically if it's not written down, it's very hard to evidence what was discussed.

Liz Bardolph:

Very hard indeed. Yes.

Ron Myers:

Okay. Right. So, can you just remind us as well of the actual legal requirements concerning consent and repeat consent as well.

Liz Bardolph:

There are four main legal requirements to consent, and these were clarified and redefined in a particular case known as Montgomery vs Lanarkshire Health Board in 2015. It didn't change the consent process, but they did clarify it and shifted the focus from the patient's autonomy and partnership, and away from paternalism, which was a doctrine which was gradually disappearing anyway. So the four pillars really are, the procedure must be explained, the alternatives be discussed and we've already touched on that, the risks are to be discussed and questions to be answered truthfully, and we've talked about questions as well.

Ron Myers:

Okay, fine.

Liz Bardolph:

I read in an article in a B&J several years ago that there was quite a useful synonym for this. It was procedures, all alternatives, risks and questions. And you can break that down to P-A-R-Q. And that's actually quite easy to remember, PARQ. And if you go through all those, then you've covered everything.

Ron Myers:

Oh, that sounds excellent. So it's quite an easy thing to kind of keep in your head then, isn't it that? I like that.

Liz Bardolph:

Yeah. PARQ. Great.

Ron Myers:

PARQ. P-A-R-Q. Lovely. And also just from a technical perspective, is the Bolam test still relevant to the consent process?

Liz Bardolph:

Not any longer, no. It's been overtaken by the Montgomery because of this patient autonomy. The Bolam test asks if the doctor's conduct would be supported by a responsible body of medical opinion, in effect, allowing the medical profession to arbitrate. The defence won't succeed even if there's that support for the defence who're in the minority, as long as they're not irresponsible, not respectable or incompetent. So the Bolam test has been completely replaced in respect of the consent process by Montgomery, which is patient-centred, i.e. was the patient made aware of the material risks and of any reasonable alternatives. We keep coming back to these two points, risks and alternatives.

Ron Myers:

Right. Okay, fine, that's brilliant. Thank you. Do you have any other tips or information that you'd like to give our listeners concerning the consent process?

Liz Bardolph:

I think that's probably covered it. It's just I think we all need to remember that with both non-medics and medics, the law of negligence applies to all of us. We touched on bombarding the patient with information. I think, what we need to say, even if the risk is statistically low - for the particular patient you've got in front of you, it may be high. So, that's worth remembering. For instance, bruising. If they're not in the public eye, some people won't bat an eyelid if they're going to be bruised for a day so, but there will be others who will not be very impressed. I think you also need to tell practitioners, practitioners need to tell patients about less serious complications if they occur frequently, for instance, prolonged swelling, lumps and bumps. People get pretty upset if this happens and they were not warned properly about it.

Ron Myers:

Yeah. I suppose it's then also looking at the very rare but also serious complications. So I mean, one of those is in relation to dermal fillers, which probably 15 years ago nobody would have discussed, but now is well-documented, and that's potential blindness.

Liz Bardolph:

Yeah. I do think this does need to be mentioned. It's statistically low but it counts. And I think really it is something we've got to broach with our patients. After all, these treatments aren't essential. They may be essential to some people in some ways, but you know what I mean. That they're not medically essential. So I think it may have perhaps put some people off, if you tell them that there is a possibility of this particular complication or even a vascular occlusion. I have discussed this with some patients, certainly for lip augmentations, and the youngsters, it's made them think twice. Do I really want to go ahead with this?

Ron Myers:

Well, this is it, and I think again, it's providing people with all of the information that is relevant to that situation, isn't it, really, and then it's up to them to make their, as you say, informed decision as to whether they want to go ahead or not.

Liz Bardolph:

Absolutely. Yes.

Ron Myers:

Lovely. All right. Well, thank you, Liz. That's been really, really useful. I wish you all the best of luck over the next few weeks, and let's all hope that we can start to get some sort of normality, whatever that will be, again soon.

Liz Bardolph:

It will be very nice to get back to seeing patients. I have to say, I do miss them.

Ron Myers:

Yeah. Lovely. Thank you, Liz. Thanks for your time. Bye.

Liz Bardolph:

Thank you, Ron. Bye bye.