Division d'orthopédie
ASSOCIATION CANADIENNE DE PHYSIOTHÉRAPIE

Orthopaedic Division
CANADIAN PHYSIOTHERAPY ASSOCIATION

INFORMED CONSENT DISCUSSION FOR SPINAL MANIPULATION CLINICIAN'S RESOURCE

This resource has been developed to support informed consent practice in spinal manipulation. It serves as a reference for clinicians and instructors, and as a preparation guide for candidates challenging the practical examinations.

Before conducting an assessment or providing treatment, physiotherapists must get a patient's permission to do so. This is known as consent. The physiotherapist must be sure the patient understands what is going to happen before the treatment begins by providing information about the nature of the treatment, its benefits, risks/ side effects (minor and major), the alternative courses of action, and any possible consequences of not having the treatment. The physiotherapist must also answer any questions the patient may ask about the treatment.

CONSENT DISCUSSION CHECKLIST [1, 2]

1. **Confirm Capacity to Consent**

   Can the patient understand and appreciate the decision?
   Are there any factors that may be impairing their capacity today?
   If the patient is not capable of providing consent, the physiotherapist must find a substitute decision-maker to provide consent.
   Physiotherapists cannot make decisions on behalf of a patient. The only exception is in an emergency when there is no substitute decision-maker available to make the decisions.

   If the patient is under 18: capacity to consent is not determined by age alone. A minor may provide valid independent consent if they demonstrate the ability to understand the nature and purpose of the proposed treatment and appreciate the consequences of consenting or refusing. Factors to consider include maturity, cognitive ability, complexity of treatment, seriousness of condition, and related risks. If capacity is in doubt, involve a parent or guardian. Document your assessment.

2. **Explain the Nature of the Treatment**

   Describe quick controlled force applied to a spinal joint.
   Explain the possibility of an audible 'pop' (cavitation).
   Identify the specific region being treated.

3. **Discuss the Benefits**

   Pain reduction, improved range of motion and mobility
   Reduced muscle spasm / tightness
   This may be short-term (2-3 days) and in some cases longer
   Functional improvement – individual responses will vary

4. **Discuss the Adverse Events/Risks**

   Material risk = *any risk a reasonable patient would want to know about, including: (a) common risks regardless of severity, and (b) rare risks that are serious or life-altering. Both must be disclosed.*

   Minor (common): localized increase in muscle or joint soreness/stiffness, temporary symptom increase, mild headache or dizziness which typically lasts 24-48 hours

   Major: refer to the table for adverse events/risks in each spinal region

5. **Confirm the Right to Refuse / Withdraw**
   Patients are entitled to refuse to consent to treatment or withdraw their consent at any time.

   Consent may reasonably persist when treatment plan, risks, and patient circumstances remain unchanged. Re-consent is required when there is a meaningful change (new technique, new region, significant gap between visits, change in condition, new provider involved).

6. **Obtain and Document Consent**

   Use teach-back: 'Can you describe the main risks in your own words?'
   Confirm consent if voluntary, informed, and covers material risks (risks that are frequent, or rare but serious).
   Having a patient sign a form is NOT considered obtaining consent – what must be documented is the conversation.
   Document capacity confirmed, topics covered including material risks, questions answered, form of consent (verbal/written), and providers involved.

Consent can be given verbally, in writing, or it can be implied through behaviour. For example, the patient rolls up their sleeve for their arm to be examined.

Physiotherapists must document their conversations with patients about ongoing consent to assessment, treatment, and involvement of other care providers, including physiotherapist assistants.

7. **Alternatives to Manipulation**
   Present clinically relevant options before obtaining consent.

   Manual therapy – mobilizations, soft tissue massage / myofascial release, neural mobilizations
   Active / Exercise – therapeutic exercise, motor control, directional preference exercises, postural retraining
   Other – acupuncture, dry needling, heat/cold therapy, electrotherapeutic agents

BENEFITS, ADVERSE EVENTS/RISKS BY SPINAL REGION

Region	Benefits	Minor Adverse Events/Risks	Major Adverse Events/Risks
Cervical	Reduced neck pain & headache Improved ROM & mobility Decreased muscle spasm/tightness Relief of cervicogenic headache Improved function	Local soreness or stiffness Temporary increase in symptoms Mild headache or transient dizziness	Vertebral artery dissection / vertebrobasilar stroke [3] Carotid artery dissection [3] Spinal cord injury TIA; death (extremely rare) [3] Red flags: sudden severe headache, diplopia, ataxia, facial droop, limb weakness → CALL 911
Thoracic	Reduced mid-back pain & stiffness Improved thoracic mobility & posture Indirect relief of shoulder/rib symptoms Benefit for mechanical neck and shoulder pain via thoracic techniques Improved function	Local soreness or stiffness Temporary rib discomfort Mild fatigue	Rib fracture (risk increased with osteoporosis) [5] Pneumothorax [5] — rare; unilateral chest pain + dyspnea → CALL 911 Spinal cord compromise [5] Disc herniation with neurological deficit
Lumbar	Reduced low back pain (acute & subacute) Improved lumbar ROM Decreased muscle spasm Reduction in referred/radicular leg pain Improved function	Local soreness or stiffness Temporary increase in leg symptoms Mild fatigue	Cauda equina syndrome [4]— EMERGENCY: new bowel/bladder incontinence, saddle anaesthesia, bilateral leg weakness → CALL 911 Central disc herniation or extrusion [4] Lumbar facet fracture [4] (osteoporotic patients) Worsening of pre-existing radiculopathy
Pelvis / SI joint	Reduced SI joint & pelvic girdle pain Improved pelvic mobility Improved gait mechanics Improved function	Local SI/gluteal soreness Mild hip discomfort Temporary increase in leg referral	Hip labrum/acetabular irritation (supine gapping technique) Hip OA flare-up lasting >2 weeks Lumbar disc injury or facet fracture (side-lying technique) Pregnancy: no confirmed causal link to miscarriage; caution warranted with high-risk obstetric history

References:

[1] College of Physiotherapists of Ontario https://collegept.org/resource/consent/

[2] College of Physiotherapists of Alberta https://www.cpta.ab.ca/for-physiotherapists/resources/guides-and-guidelines/consent-guide/

[3] Kranenburg HA, Schmitt MA, Puentedura EJ et al. Adverse events associated with the use of cervical spine manipulation or mobilization and patient characteristics: A systematic review. *Musculoskelet Sci Pract*. 2017 Apr;28:32-38. doi: 10.1016/j.msksp.2017.01.008.

[4] Hebert JJ, Stomski NJ, French SD, Rubinstein SM. Serious Adverse Events and Spinal Manipulative Therapy of the Low Back Region: A Systematic Review of Cases. *J Manipulative Physiol Ther*. 2015 Nov-Dec;38(9):677-691. doi: 10.1016/j.jmpt.2013.05.009. Epub 2013 Jun 17. PMID: 23787298.

[5] Heneghan NR, Pup C, Koulidis K, Rushton A. Thoracic adverse events following spinal manipulative therapy: a systematic review and narrative synthesis. *J Man Manip Ther*. 2020 Dec;28(5):275-286. doi: 10.1080/10669817.2020.1725277. Epub 2020 Mar 9. PMID: 32148185;