Diagnosis: Duty and defensibility

Position statement

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What is a diagnosis?

In legal terms, a ‘diagnosis’ is the professional identification of a condition. A competent practitioner undertakes a clinical assessment (comprised of both a subjective and objective element) and subsequently forms a diagnostic opinion. The preferred term suggested by legal representatives is ‘reasoned clinical assessment’ and The SST also recommends referring to this as a ‘diagnosis hypothesis’. A true diagnosis can only be confirmed by gold standard testing, which in the case of most MSK injuries, would involve an MRI, CT scan or blood tests. Most clients’ injuries are not severe enough to warrant a confirmatory test such as this, as it would not change the treatment plan or the prognosis, so a Graduate Sports Therapist* is often left working comfortably from their diagnosis hypothesis.

Can a Sports Therapist diagnose?

The short answer is Yes. Graduate Sports Therapists are permitted to form diagnostic opinions within their scope of practice.

From a legal perspective there are only protected titles (such as paramedic) not protected acts. Therefore, there is no statutory restriction preventing any competent practitioners from forming or expressing a diagnostic opinion. For Graduate Sports Therapists this means there is no express statutory prohibition on diagnostic activity by Sports Therapists provided they act within scope and competence. The SST’s curriculum, governance, and referral standards ensure that assessments are legally compliant and defensible when appropriately documented and communicated.

Our duty

Some challenge the idea that not all injuries need a diagnosis: that we should always adopt a biopsychosocial approach rather a pathoanatomical approach and in some cases a diagnosis may even be harmful to the client.

In response, The SST suggests that all clients should be assessed sufficient to develop a sound and clinically reasoned diagnosis hypothesis. Communication of the diagnosis hypothesis should be tailored to the client’s preferences and needs. Some clients may want the specific hypothesis so that they can research the injury and better understand the reason for their pain or impairment. Other clients may find the details of the diagnosis hypothesis distressing or a cumbersome burden, and in these cases, the explanation may be adapted to de-threaten or de-escalate anxiety around their symptoms. Regardless of your communication to the client, a Graduate Sports Therapist has a duty to develop a working hypothesis.

*Graduate Sports Therapist refers to a Member of The SST.

The ‘hypothesis’ element of a ‘diagnosis hypothesis’ is critical. It should not be regarded as a fixed or irreversible conclusion. Instead, we encourage members to review and refine the diagnosis hypothesis at every client interaction. For example, during an acute or immediate post-injury assessment, clinical findings can be misleading: pain may be widespread, range of motion severely restricted, swelling pronounced, and weight-bearing impossible. In such cases, deductive reasoning based on the mechanism of injury and initial clinical impressions allows the therapist to form a leading diagnosis hypothesis while maintaining a broad set of differential diagnoses. Initial management may include acute injury advice, protective measures such as a boot, sling, or crutches, and, where appropriate, referral for imaging. At subsequent reviews, as symptoms settle and distracting factors diminish, the therapist can reassess and refine the diagnosis hypothesis with greater accuracy.

It is essential to apply the principle often referred to as Jess’s Rule: if a client is not improving as expected, or their condition is deteriorating, the diagnosis hypothesis must be reviewed. Where the clinical presentation does not align with anticipated progress, the therapist should reflect, reassess, revisit differential diagnoses, and, where appropriate, initiate referral. Referral may be to a more experienced practitioner or to a specialist within or outside the musculoskeletal field. Recognising when a case falls beyond one’s scope of practice is a fundamental professional responsibility.

Defensibility

Defensibility means the ability of clinical documentation and decision-making to withstand legal or regulatory scrutiny by being accurate, complete, and justifiable based on accepted standards of care and evidence.

Should a claim be made against a Graduate Sports Therapist, the law assesses professionals against peers of similar qualifications and scope, not statutory title. This means that a court would judge your actions against similarly qualified Graduate Sports Therapists. It is important to understand how we can improve our ‘defensibility’ in these situations by considering informed consent, note taking, referral practices and peer-defined scope of practice.

Consent

Consent simply means the voluntary and revocable agreement of a competent client to undergo a therapeutic or diagnostic ‘procedure’, based on an adequate understanding of its nature, purpose, risks, benefits, and alternatives.

Consent must be obtained prior to any client contact involving assessment or treatment. Informed consent requires full disclosure, including clear and accurate information about the proposed intervention, associated risks (including serious or permanent injury), expected benefits, likely outcomes, and reasonable alternatives such as the option of no treatment.

Another basic principle is voluntariness - the decision should be made freely, without coercion or undue influence. The client should also have the capacity to understand and make decisions. Consent should also be documented and recorded in detail. Consent is always revocable meaning that consent can be withdrawn at any time, for any reason. Written consent is always advised over verbal or implied consent (i.e. where the client simply follows the therapists' instructions as an indicator of consent).

Following a full explanation to client, we recommend that consent is achieved by asking 3 simple questions:

- Do you understand the information provided?
- Do you have any questions?
- Are you happy for me to proceed?

Documentation should confirm that the three informed consent questions were asked and that the client provided full written consent.

Note taking

Note taking is the cornerstone of defensibility. Notes act as a contemporaneous record of assessment, diagnosis hypotheses, treatments and rehabilitation which courts and insurers view as objective and credible evidence. In negligence claims, detailed documentation of decisions and reasoning helps demonstrate adherence to appropriate standards and scope of practice, reducing liability risk. Notes also help establish key legal elements such as the extent of injury – its severity at the initial consultation and its progression, and causation (timely notes can link injury to an incident). Notes are also key in ensuring safe, coordinated care across a multidisciplinary team or where multiple MSK clinicians are involved in the client's care. They also demonstrate compliance with ethical and professional standards, reinforcing professional credibility. Poor or missing notes have been estimated to double or triple the odds of an indemnity payment in malpractice cases.

To help support members The SST has produced the following documentation that members can access by logging in to their SST account:

- Standardised use of abbreviations
- Example of an Examination and Assessment Consultation form
- Example of a Follow-Up Consultation form

Referral

Referral is a critical component of defensibility and client safety. Initiating a referral demonstrates a commitment to prioritising care, acknowledging professional limitations, and acting appropriately when a client's presentation falls outside one's scope of practice. Failure to refer in a timely and appropriate manner may constitute negligence if harm results from a delayed or missed diagnosis.

When clinical findings indicate that specialist input is required, referral should be made promptly and documented. This process is typically undertaken through a formal referral letter, which should include relevant clinical details, suspected diagnosis, prior management, and the level of urgency.

When the client's symptoms indicate a condition requiring specialist assessment, it is essential to initiate a referral. This is typically completed through a formal letter.

The fundamental components of a referral letter should include:

- Reason for referral.
- Detailed clinical findings: relevant history, subjective and objective assessments.
- Suspected diagnosis.
- Previous management.
- Level of urgency: aligned with current practice guidelines or national pathways (e.g. MRI timing standards or UK pathways such as Cauda Equina Syndrome).

An example of a referral letter is available to SST members.

Clear communication with the client is essential when initiating a referral. The rationale for the referral should be explained, along with details of the service or practitioner to whom the client is being referred, expected timeframes, and any follow-up arrangements. Where appropriate, clients should also be informed of their right to seek a second opinion.

Understanding your scope of practice

In UK healthcare law and professional regulation, scope of practice refers to the legal, professional, and competency boundaries within which a clinician is authorised to work. It is defined by a combination of statutory law, regulatory frameworks, and professional standards. At its core, scope of practice is:

The range of activities, procedures, and responsibilities that a health professional is permitted to perform, based on their education, training, competence, and legal authority.

As a Graduate Sports Therapist, your degree was accredited by The SST. As part of this we ensured that all educational competencies were met and that you were appropriately taught, assessed and deemed competent in these areas.

Regarding clinical assessment, The SST Educational Competencies (2025) state a Graduate Sports Therapist should be able to:

2.1 Apply a working knowledge of anatomy, physiology, biomechanics and pathology to MSK clinical examination and assessment.

2.2 Recognise typical presentations of MSK injuries and non-MSK conditions across all populations.

2.3 Conduct a thorough subjective assessment sufficient to establish a potential tissue hypothesis, a diagnosis hypothesis, differential diagnoses, red flags and non-MSK pathology indicators.

2.4 Conduct a thorough objective assessment sufficient to confirm/refute the diagnosis hypothesis, that may comprise of observation, quick touch, range of movement assessment (active, passive and resisted), accessory movements, manual muscle tests, ligament stress tests, palpation, 'special' tests, neurological tests and other functional tests as deemed clinically relevant.

2.5 Refer patients to the appropriate care pathway where there are concerns for the patient, the working hypothesis is non-MSK in nature or where MSK imaging or surgical consultation is required.

2.6 Use clinical reasoning at every stage of the clinical examination and assessment process with an appreciation of current evidence for the clinical usefulness of individual and test clusters.

As a graduate of an SST-accredited degree programme, the competencies achieved during training form an integral part of the professional scope of practice. These skills should be maintained through regular application, reflective practice, and engagement with current evidence and best practice.

Additional skills gained through continuing professional development (CPD) or further training may only be incorporated into an individual's scope of practice when specific criteria are met:

1. Appropriate education and training for the skill have been completed.
2. Competence can be demonstrated through assessment or credentialing.
3. The activity is permitted by law and recognised by The SST.
4. Professional indemnity and insurance coverage are in place.
5. The skill can be performed safely and effectively within the practitioner's role, without breaching ethical or legal standards.

Attendance at short courses or observations alone would not meet these thresholds. Performing a skill without adequate training or assessment may leave the practitioner professionally vulnerable.

Conclusion

In summary, Graduate Sports Therapists are both permitted and professionally expected to form clinically reasoned diagnostic hypotheses within their scope of practice. While diagnosis is not a protected act, it carries significant responsibility - requiring sound clinical reasoning, clear documentation, informed consent, and appropriate referral when necessary. By adhering to these principles and maintaining defensibility through robust note-taking and ethical decision-making, therapists can safeguard client welfare and uphold professional standards. Ultimately, our role is not to provide absolute certainty but to deliver safe, evidence-based care that prioritises the client's best interests.