University of Brighton

Investigating osteopathic patients' expectations of osteopathic care: the OPEn project

FULL RESEARCH REPORT

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CONTENTS

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Study web site: http://www.patientexpectationstudy.org.uk/

Other reports on this study are available from the GOsC web site. Titles are:

- **The OPEn project investigating patients' expectations of osteopathic care: Summary Report**
- **The OPEn project investigating patients' expectations of osteopathic care: Report for osteopaths and the public**
- **The OPEn project investigating patients' expectations of osteopathic care: Supplement for NHS participants**

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Summary of key findings

The main aim of this study was to gain an understanding of the expectations of patients receiving osteopathic care, and to quantify the extent to which their expectations were being met.

The General Osteopathic Council commissioned this research in response to the increasing emphasis nationally on patient-centred care. The GOsC envisaged that the outputs from the study might be used for timely, targeted guidance to the profession on practice issues.

The research team tendered competitively and won the commission to conduct the research. The GOsC appointed a steering group (see Appendix 2) to oversee the progress of the study. To enhance involvement and information access for patients and osteopaths, a web site for the study was set up and details were posted on it throughout the course of the study.

The study design comprised three complementary phases to gain knowledge about the expectations of osteopathic patients, using mixed methods including both qualitative and quantitative methodologies. Focus group discussions and individual interviews with a diverse range of osteopathic patients were used to gain understanding of patients' expectations of osteopathy. A questionnaire survey was used to identify the most important expectations and unmet expectations; a large representative sample of patients was recruited by osteopaths who were randomly sampled from the UK Statutory Register of Osteopaths. Under-pinning both parts of the study was a literature review, conducted to establish what was already known about patients' expectations within osteopathy and related areas of health care.

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Phase 1: The literature review

The aim was to review existing evidence about patients' expectations within osteopathy, other manual therapies and other branches of health care.

A large body of relevant literature revealed that expectations in health care can influence outcomes such as satisfaction and effectiveness of treatment. Theoretical models of expectation refer to the "gap" between patients' expectations of a service and the service they perceive to be given. The unmet expectations in this gap have been shown to influence outcomes directly, and hence needed to be included in this project.

The patient factors that shape expectations include their health condition, their interpretation of their symptoms and their beliefs about the possibility of improvement; their psychological characteristics and associated beliefs and vulnerabilities; and their beliefs about the treatment based on their own or others' experience . These beliefs and expectations are very much influenced by cultural factors such as ethnicity and religion, socio-demographic factors such as age, education and income, and vulnerability due to disability or incapacity. The healthcare factors that shape expectations can be divided into two groups: structural factors describing the way the service is organised, and process factors describing the therapeutic encounter itself. Structural factors include the way the service is organised, such as whether it is private or NHS funded, waiting times for appointments, ease of access, efficiency of referral, third parties and chaperones. The therapeutic encounter includes the quality of the consultation with the practitioner (personal factors such as trust, communication, congruence of understanding, confidence) and the technical quality of the delivery of information, diagnosis and treatment.

The literature review was drawn from a total of 1108 papers, the majority published since 1970, within which there were 135 key papers: 18 focussing on expectation in complementary therapies, 11 within manual therapies, 10 within osteopathy; there were 89 reporting on features of expectation and 7 related to patient satisfaction.

The literature focussed on:

- Definitions of expectation;
- Theoretical models of expectation;
- Factors influencing expectation;
- Patients' expectations of all healthcare practitioners;
- Expectations of the consultation;
- Expectations of osteopathy (preliminary evidence);

- The relationship between expectation and satisfaction.

The distinctive characteristics of osteopathic patients were:

- Having musculoskeletal problems, often chronic;
- Less worried about side effects of allopathic medicines than the generality of CAM patients;
- Private patients may bench-mark the quality of the service against NHS and other services.

The patients' expectations of the osteopathic service were related to five topic areas:

- Clinic Environment (healing, accessible, flexibility of appointments);
- Professionalism (continuity of care, technical skill);
- Treatment (effective manual treatment, physical realignment of the spine, advice and prescription of exercise, an holistic approach);
- Relationship (inter-personal skills; offers hope, communication, respect and trust; shared decision- making tailored to the individual);
- Outcome (reduction of pain, improved quality of life).

Two possibly unmet expectations were identified: forewarning patients about the need to undress, and evidence of discordance between patients and practitioners (chiropractic) in relation to expected improvement in symptoms.

All this evidence was preliminary, being based on small studies and required testing in further research. The above factors can be considered as probably relevant to osteopathic patients, whereas the relevance of the other factors that were identified within the literature review was unknown until the subsequent phases of the study were conducted. All the identified factors became candidate topics for use in the focus groups, and contributed to the development of the questionnaire for phase 3 of the current study. No standardised instrument to measure expectation was found to exist; a questionnaire therefore needed to be developed for the survey in phase 3.

The full findings of the literature review represent a unique overview of patients' expectations within healthcare and will be published as a scientific paper in the near future.

Phase 2: focus groups and individual interviews with osteopathic patients

New understanding of expectations of osteopathic patients was gained through in-depth focus groups and individual interviews with 36 participants, who were patients drawn from 14 private osteopathic practices in 11 locations across England, Wales, Scotland and Northern Ireland. The patients were diverse, ranging in age from 17 to 84 years, in ethnicity, and in socio-economic background. The rich, in-depth data represented over 15 hours of discussion, which were transcribed verbatim and analysed thematically to create a model specifically of the expectations of osteopathic patients.

A model of osteopathic patients' expectations emerged comprising five broad themes, each containing a number of topics:

(1) **Individual agency** representing the patient's ability to take control of their own condition and make an informed choice about their treatment/management; their need to understand their problem, and the decision to pay for care even if financial sacrifice may be involved;
(2) **Professional expertise** representing the patient's desire to access the osteopath's specialist knowledge and manual and information-giving skills, their wider knowledge of treatment options, and professional conduct with clear boundaries;
(3) **Customer experience** representing the expectation of appropriate attitudes of staff and the therapeutic environment within the practice to build rapport, together with flexible appointment times and value for money;
(4) **Therapeutic process** representing expectations of the consultations, including sufficient time for manual treatment that impacted on symptoms, on-going care if required, and involvement of the patient if they wanted it, in treatment planning and self-management;
(5) **Interpersonal relationship** which was a theme that was recurrent throughout the transcripts, and represented being believed that symptoms were real, the development of a trusting relationship with the osteopath, and having a sense of connection with their practitioner.

Some unmet expectations were raised: some patients suggested that they received insufficient preparation for the (forceful) nature of the intervention so that the experience of osteopathic "crunching", and the level of side-effects after treatment, came as a surprise. Some were

unhappy about having to undress, or had not realised that it would be required. There was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this is an area of concern for patients where expectations may possibly be unmet. Some participants described previous experiences that had not met their expectations in terms of the environment (lots of cuddly toys in the room) or the professional conduct and manner.

The themes, together with the topics sub-themes and topics within them, were all used to develop questions for inclusion in the survey questionnaire.

Phase 3: a national survey of osteopathic patients

The aim of the third phase of the study was to evaluate osteopathic patients' expectations and the degree to which they were met. A national survey was conducted, distributing a specially designed questionnaire to a large, representative sample of patients attending 800 private osteopathic practices.

The sample of osteopaths was created from the Statutory Register provided electronically by GOsC. The osteopaths were each asked to recruit 14 consecutive adult patients.

The rate of participation of the osteopaths was 32.4%, which meant that of the 11,200 questionnaires we mailed out, it is probable that no more than 3,626 (259 x 14) were distributed to patients. Of these, a total of 1701 questionnaires were received from patients, representing a patient response rate of 46.9%. This puts into perspective the rather low overall response rate of 1,701 out of 11,200 questionnaires sent out, or 15.2% overall. Of the 1,701 questionnaires received, a total of 1,678 were included in the analysis.

Over 96% of the 1678 respondents were satisfied or very satisfied with their osteopathic care, and only 0.3% were unsatisfied, providing a very positive message for the profession.
The top expectations which emerged were, firstly 5 statements that respondents strongly agreed with, that they expected:

- for the osteopath to only treat one patient at a time;

- to be reassured that the information they were asked to provide would be kept confidential;
- for the osteopath to take a detailed account of their clinical history;
- to be treated with respect;
- for the osteopath to listen to them.

Secondly, respondents named their "most important expectations", in their own words, and the six most important expectations were:

- To have an immediate, perceptible improvement in symptoms;
- The osteopath to be caring and listen to what I have to say;
- To be able to return to their normal activities/have an improved quality of life;
- To be given advice on how to manage their problem and prevent recurrence/ worsening of symptoms;
- To be given a clear and honest explanation of their problem and what can be achieved;
- Their problem to eventually resolve completely as a result of the treatment;
- To receive appropriate, effective treatment.

The following were the best met, with less than 1% of respondents having unmet positive expectations:

- To be treated with respect;
- To be able to ask questions;
- For questions to be answered to their satisfaction;
- The osteopath to listen to them;
- The osteopath to be sympathetic towards their problem;
- The osteopath to make them feel at ease;
- The environment to be hygienic and professional;
- The osteopath to examine their specific problem area with her/his hands;
- The osteopath to write down their personal case history;
- The consultation to last at least thirty minutes;
- To be given an explanation of the cause of their problem that they were able to understand;

- Their treatment to be value for money.

The worst met expectations were

- To be made aware that there was a complaints procedure should they need to use it;
- For there to be communication between their osteopath and GP about their problem;
- To be informed of the risks and side effects of treatment;
- For there to be access for people with disabilities;
- For the osteopath to be able to refer them elsewhere when their symptoms did not improve;
- To be asked about the effects of previous treatment;
- For the osteopath to assure them that their details were kept confidential;
- To be given the opportunity to receive advice from the osteopath over the telephone;
- Before their first appointment to be given information about what would happen during treatment.

In addition, in the free text questions some patients mentioned unexpected treatment modalities such as acupuncture (N=33), cranial osteopathy (20) and ultrasound (8).

The patient characteristics collected showed that respondents were rather homogeneous with respect to educational level, ethnicity (white) and employment status. Homogeneity increases the robustness of the findings but limits their generalisability to non-white or socially less advantaged groups.

Discussion of the implications for the profession

All three phases of the project contributed to meeting the brief and answering the research questions for patients attending private osteopathic practices in the UK.

Firstly, the aspects of osteopathic care about which osteopathic patients have expectations were identified within the literature review (phase 1) in outline, and by the focus groups and interviews with osteopathic patients (phase 2) in greater depth. The survey (phase 3) was then used to quantify the relative importance of each of the 51 identified aspects of expectation, and to elicit further expectations for use in future research. In addition, an understanding of

the relationship between the components of expectation was gained from all three phases and a model emerged which provided insight on patients' perceptions of care.

Secondly, the extent to which osteopathic patients perceive that their expectations were met or unmet was suggested by the interviews in phase 2, and quantified accurately by the survey questionnaire in phase 3.

Thirdly, the way that expectations may vary according to patients' characteristics was described by the literature review, based on studies across a range of types of healthcare; some insight was also provided by the focus groups and interviews. The survey showed that the expectations of new patients were very similar to those of returning patients with prior experience of osteopathy. However, the sample of osteopathic patients that responded to the survey was too homogeneous to permit sub-group analysis of variation within minority groups.

The consistency of the findings across the three components of the study lends weight to the findings, which are considered to represent robust evidence about the expectations of osteopathic patients**.**

The most important expectations and the worst met positive expectations that were identified in the survey will enable the profession to set priorities for improving care: for the regulator as part of the standards, for educators as part of training, and for practices as part of service delivery. As emphasised by the literature review, gaps between expectations and delivery of care have a negative effect on outcomes of care.

For the Regulator, the findings highlighted the areas where targeted guidance to the profession on practice issues might be required; and the obstacles to disseminating the findings of the study to the profession. The priority areas are outlined under implications for the profession, below. Secondly, the expectations of patients which were not covered by the Osteopathic Code of Practice were highlighted. When next reviewing the Code, the GOsC may need to consider both the patient-centred model of expectations and those specific expectations which are not included within the current Code of Practice. In particular, there were a several statements about aspects of the therapeutic process which appear to be without

corresponding clauses in the Code of Practice; this seemed surprising as the results suggested these issues were important to patients.

For the profession, the implications related to improving the delivery of care. The priority areas in relation to each theme were:

- For **individual agency,** to support patients' need to know about their problem, by providing clear information and advice about the problem and on how to prevent it recurring;

- In terms of **professional expertise,** to enhance and perhaps make more explicit the process of effective triage at first appointment, with referral if required;

- To provide a quality **customer experience,** the osteopath should treat only one patient at a time (Note: this was the highest of all patients' expectations); and provide information about how to make a formal complaint (Note: this was the worst met of all expectations);

- to provide a patient-centred **therapeutic process, p**atients need to know what to expect in relation to treatment and pain it may cause; they may benefit from pre-attendance information about the nature of treatment and the likely after-effects, and reassurance about the level of pain that might be experienced during treatment;

- to improve **interpersonal relationship**, the osteopath should consistently provide information about risks and side effects of treatment and reassurance of confidentiality.

For **professional training and for CPD,** the main implications involved the need for training and support beyond the scope of osteopathic technique and professional practice, and particularly in the following areas:

- Inter-personal skills , such as communication skills and empathy;
- Personal development and psychological health;
- Evidence and judgement of clinical risks;

- Professional conduct and boundaries in respect of touch and clinical examination; perhaps incorporating aspects of medical clinical training, to develop a "GP-like" approach to touch;
- A broad knowledge of other types of health care and how to forge links with other healthcare professionals for referral purposes.

Finally, the findings of high levels of satisfaction and expectations mostly met well provided the profession with much to be proud of; and the study provided valuable indications about how to make osteopathic services even better.

Conclusions

Further survey research is recommended to confirm the current findings and to evaluate expectations within different populations of osteopathic patients.

The study methodology generated robust and valuable data at each stage, and answered the initial research questions. The research generated rich data for the profession, for the training establishments, the Regulator and for patients. Material for disseminating the results to these target audiences will be produced in liaison with the professional organisations within osteopathy.

The profession is now able to guide patients about what is reasonable to expect when they visit the osteopath. Patients can confidently expect that they will be treated with respect, listened to, and provided with a good explanation of their problem. Patients may need to understand that certain expectations are hard to meet, such as a choice of male or female osteopath, or telephone advice from the osteopath.

The methodology and the questionnaire are now resources for future research, including surveys in other settings such as OEI clinics or NHS services. Other areas for further research include surveys in minority groups of patients and of osteopaths, research to gain understanding of patients' unmet expectations, and exploration of expectations about the nature of treatment.

Chapter 1 Introduction and background to the study

Summary of Chapter 1

The main aim of this study was to gain an understanding of the expectations of patients receiving osteopathic care, and to quantify the extent to which their expectations were being met. The General Osteopathic Council commissioned this research in response to the increasing emphasis nationally on patient-centred care. The GOsC envisaged that the outputs from the study might be used for timely, targeted guidance to the profession on practice issues. The research team tendered competitively and won the commission to conduct the research. The GOsC appointed a steering group (see Appendix 2) to oversee the progress of the study. To enhance involvement and information access for patients and osteopaths, a web site for the study was set up and details were posted on it throughout the course of the study. The study design comprised three complementary phases to gain knowledge about the expectations of osteopathic patients, using mixed methods including both qualitative and quantitative methodologies. Focus group discussions and individual interviews with a diverse range of osteopathic patients were used to gain understanding of patients' expectations of osteopathy. A questionnaire survey was used to identify the most important expectations and unmet expectations; the patient sample was recruited by osteopaths who were randomly sampled from the UK Statutory Register of Osteopaths. Under-pinning both parts of the study was a literature review, conducted to establish what was already known about patients' expectations within osteopathy and related areas of health care.

1.1 Background to the project

The Darzi report (Darzi, 2008) focussed attention on patients' needs in healthcare[1]. Research had shown that patient expectations are very complex and have a significant impact on outcomes of care (Belle-Brown, 2003; Little, 2004). The General Osteopathic Council (GOsC), the regulator of osteopathy in the United Kingdom (UK), responded to this initiative in August 2008 by commissioning work to investigate patients' expectations of osteopathic care. The GOsC invited bids for research which would "provide clear and detailed data on the patient's perspective of osteopaths and osteopathic care". Bids were expected to result in information that contributed to the ability of the GOsC to set appropriate standards relating to osteopathic practice and issue guidance where necessary to osteopaths. The work was expected to inform training standards and continuing professional development for osteopaths.

The rationale behind the commissioning was explained in the call for proposals by the GOsC: "The General Osteopathic Council is embarking on a programme of research aimed at providing the kind of data that will help it discharge its statutory functions more effectively. It is particularly important, given the GOsC's primary statutory objective to protect the public, that we gain a much more detailed understanding of the expectations of patients seeking osteopathic treatment". Reliable and up to date data on patients' expectations would be used to inform the GOsC's policy making. One possible outcome of the use of such data would be the issuing of timely, targeted guidance to the profession on practice issues.

In preparation for his book, "Osteopathy in Britain – The First Hundred Years", Dr Martin Collins extensively examined the development of osteopathy in the United Kingdom. His research included interviews and examination of archival documents. One telling comment was made by the late Fyfe Robertson, a well-known broadcaster with the BBC (Robertson, 1949). He stated that "Most people know very little about osteopathy, and that little is usually wrong". In a similar vein, the same could also be said about many patients and their expectations of osteopathic care; members of the profession believe that, as highly-trained healthcare professionals, they know what patients want, but how much of that is in fact erroneous?

1.2 Aims and purpose of the research

The aim of the project was to gain an understanding of patients' expectations of osteopaths and osteopathic care, and to quantify the extent to which expectations are met. This was expressed as three research questions:

1. What are the specific aspects of osteopathic practice about which patients have expectations?
2. To what extent do patients perceive that their expectations are met or unmet?
3. How do expectations vary according to the patients' characteristics and background, including minority groups?

The findings of the study will be used to assist osteopaths to improve patient satisfaction, which may also improve outcomes of treatment.

1.3 Research Methodology

Three phases of the study were conducted in order to be able to fully address the research questions and requirements of the General Osteopathic Council:

1. **A review of existing literature** was conducted to inform the study of current evidence about patients' expectations of healthcare practitioners, and to analyse the relevance and applicability of the new evidence to osteopathy.

2. **Interviews with a diverse range of osteopathic private patients** (using focus groups and individual interviews) were conducted in osteopathic practices across the UK, to elicit the diverse range of issues that osteopathic patients may consider in relation to their expectations of osteopathy. The themes and topics raised by patients were used in the development of a questionnaire in the third phase of the project.

3. **A questionnaire survey of patients in private practice:** A questionnaire was developed and piloted specifically to meet the aims of the project. The questions were based on the topics identified in the literature review and the focus group interviews. The format was mainly structured to collect quantitative data on the relative importance of the various aspects of expectation and the extent to which expectations are met. A small number of open questions enabled any additional

expectations or issues to be identified. The survey was administered to a large, representative sample of osteopathic patients across the UK.

1.4 Ethics

Approval from the Faculty of Health Research Ethics and Governance Committee (FREGC) at the University of Brighton to involve patients in private practices and at Osteopathic Educational Institutions (OEIs) was obtained in June 2009. NHS Research Ethics approval for focus groups to be held in NHS sites was obtained in 2010-2011.

1.5 Awareness of the project

A simple web site for the project was created and updated regularly, to inform the public and the profession about the aim and progress. This may be found at www.patientexpectationstudy.org.uk.

Feature articles were written by the research team for *The Osteopath* magazine, published by GOsC, and can be found in most issues of the magazine from March 2009 to April 2010.

1.6 Monitoring progress

The research team (see Appendix 1) at the University of Brighton was awarded the contract on a competitive basis in late 2008. The project commenced officially in March 2009.

The GOsC formed a steering group to advise on the project (see Appendix 2 for members). The steering group met regularly and was kept informed of progress against milestones at frequent intervals throughout the project.

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Chapter 2 Patients' expectations of healthcare – a review of the literature

Summary of Chapter 2

The aim was to review existing evidence about patients' expectations within osteopathy, other manual therapies and other branches of health care. A large body of relevant literature revealed that the relevance of expectation in health care is its influence on outcomes such as satisfaction and effectiveness of treatment. Theoretical models of expectation refer to the "gap" between patients' expectations of a service and the service they perceive to be given. The unmet expectations in this gap have been shown to influence outcomes directly, and hence needed to be included in this project.

The patient factors that shape expectations include their health condition, their interpretation of their symptoms and their beliefs about the possibility of improvement; their psychological characteristics and associated beliefs and vulnerabilities; and their beliefs about the treatment based on their own or others' experience . These beliefs and expectations are very much influenced by cultural factors such as ethnicity and religion, socio-demographic factors such as age, education and income, and vulnerability due to disability or incapacity. The healthcare factors that shape expectations can be divided into two groups: structural factors describing the way the service is organised, and process factors describing the therapeutic encounter itself. Structural factors include the way the service is organised, such as whether it is private or NHS funded, waiting times for appointments, ease of access, efficiency of referral, third parties and chaperones. The therapeutic encounter includes the quality of the consultation with the practitioner (personal factors such as trust, communication, congruence of understanding, confidence) and the technical quality of the delivery of information, diagnosis and treatment.

The literature review was drawn from a total of 1108 papers, the majority published since 1970, within which there were 135 key papers: 18 focussing on expectation in complementary therapies, 11 within manual therapies, 10 within osteopathy; there were 89 reporting on features of expectation and 7 related to patient satisfaction.

The literature focussed on:

- *Definitions of expectation;*
- *Theoretical models of expectation;*
- *Factors influencing expectation;*
- *Patients' expectations of all healthcare practitioners;*
- *Expectations of the consultation;*
- *Expectations of osteopathy (preliminary evidence);*
- *The relationship between expectation and satisfaction.*

The distinctive characteristics of osteopathic patients were:

- *Having musculoskeletal problems, often chronic;*
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- *Clinic Environment (healing, accessible, flexibility of appointments);*
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Two possibly unmet expectations were identified: forewarning patients about the need to undress, and evidence of discordance between patients and practitioners (chiropractic) in relation to expected improvement in symptoms.

All this evidence was preliminary, being based on small studies and requires testing in further research. The above factors can be considered as <u>probably</u> relevant to osteopathic patients, whereas we have no evidence at all on the relevance to osteopathy of all the other factors that were identified within the literature review. This was gained within the

subsequent phases of the study. All the identified factors became candidate topics for use in the focus groups, and contributed to the development of the questionnaire for Phase 3 of the current study. No standardised instrument to measure expectation was found to exist; a questionnaire therefore needed to be developed for this study.

The full findings of the literature review represent a unique overview of patients' expectations within healthcare and will be published as a scientific paper in the near future.

2.1 Introduction

The aim of the literature review (the first stage of the project) was to provide the contextual and theoretical background for the primary research in the subsequent phases of the project on the expectations of patients seeking osteopathic care in the UK. Since there has been scant research within osteopathy on this topic, the aim was to provide a comprehensive overview of all relevant research evidence, in order to aid understanding of expectations within osteopathy. The review aimed to identify key expectations common to all healthcare professionals, and identify any relevant survey instruments previously used in other studies which might be used in the third stage of the project. The table in Appendix 4 provides a list of the main publications used in the review, the research methodologies they used, and the healthcare specialties that they covered.

There is evidence across professions such as physiotherapy, nursing, occupational therapy and general medicine of the importance of identifying expectations and their effects on patients' satisfaction (Gerteis, 1993; Law, 1998; Rao et al., 2000; Potter, 2003). However, no investigations have been undertaken focusing exclusively on patients' expectations when consulting osteopaths for treatment. Against a background of shifting relationships in healthcare, the first part of this review outlines some relevant research into patients' expectations across a range of healthcare professions.

The Darzi report: NHS Next Stage Review (2008) reaffirmed successive government initiatives emphasising patient choice, and the greater degree of influence patients should expect to exert concerning their health management (Department of Health, 2000, 2004, 2006). Individual agency in choice of provider and the nature of treatment is expressed in a new vocabulary of relationship: partnership, concordance, therapeutic alliance, negotiation, and 'service-users' and 'clients' versus 'patients'. This more patient-centred approach to healthcare delivery implies greater levels of involvement and negotiation between patients and practitioners at all stages in the patient's journey. At the same time, patients' expectations of healthcare continue to grow as scientific advances are made and internet access to information - of variable quality - increases (Sebrell, 1953; Chappell, 1995).

The role of the patient has also changed in modern health care. A number of initiatives and organisations have been created to raise the status of the patient within healthcare. Such initiatives have included the Expert Patient Programme, patient fora and PALS. The introduction of clinical governance to the arena of mainstream healthcare in 1998 brought the concepts of patient satisfaction to the fore in the United Kingdom (Scally, 1998). Patient satisfaction is increasingly considered to be one of the most important factors in the measurement of quality of medical care (Kurpas et al., 2005); questionnaires are increasingly being used to assess all aspects of patient care (Garratt et al., 2007).

The release of the Darzi "Next Stage Review" in 2008 and the formation of the National Quality Board have re-focussed NHS policy initiatives on providing patients and the public with more information and choice, ensuring quality is at its heart. The General Osteopathic Council, acting as regulator for osteopathy in the UK is charged with protecting patient safety, maintaining and developing standards of osteopathic practice and conduct (including continuing professional development) and handling concerns or complaints (GOsC, 2000). Implicit in providing information and monitoring standards is deciphering what patients expect and helping to ensure that patients' expectations are reasonable. This review of the literature provided one aspect of gathering that knowledge.

Osteopathy as a profession is now defined and regulated by statute since the passing of the Osteopaths Act in 1993 (Osteopaths Act, TSO, 1993). Approximately 4000 individual osteopaths are on the GOsC Register and are required to act in accordance with professional guidelines; the General Osteopathic Council (GOsC) as regulator of United Kingdom (UK) osteopathy is charged with ensuring that osteopaths observe those guidelines and act at all times in the best interest of patients. The development of the GOsC Code of Practice (General Osteopathic Council Code of Practice, 2005) enshrines many of the regulator's expectations of osteopaths and the manner in which they discharge care to their patients. The majority of osteopathic services are provided in the private sector; a handful of NHS funded services existed in 2010.

2.2 Literature Search Strategy

The main research question ("what are the expectations of patients seeking osteopathic care?") comprises three fields, which were used to formulate the Boolean search terms (Straus et al., 2005). The three primary terms were patient, expectations and care (or

treatment). The search started wide, and then focussed on specifics. The terms used within the "patient" field included treatment-naïve patients, patients with specific conditions such as back pain or patients with specific characteristics such as age, culture, ethnicity, third-party funding, and obesity.

The terms used within "expectation" included belief, anticipation, hope, motive, confidence, satisfaction, preference, need, demand and choice. The terms used within "care" included treatment, therapist, outcome, consultation, communication, concordance, adherence, compliance, progress, improvement, benefit quality, as well as specific therapies such as osteopathy, chiropractic, manual therapy, primary care and complementary therapy.

A bibliographic framework was plotted to guide the literature search. Methodological and topic literature was searched; a list of key words and phrases was created to search the library online public access catalogue (OPAC) to identify authors who have produced work within the area of expectations in healthcare globally and concerning osteopathy specifically. Pearl citation searching was also employed to expand the possible literature sources. The full details of the search strategy and results can be found in Appendix 3.

2.3 Relevant literature found in the search

The number of relevant papers identified from the search was 1108, after excluding duplication between sources. Of these, 388 were from PUBMED, 324 from other research databases, and 205 from Google Scholar. A small number of papers were of systematic reviews and randomised controlled trials, the majority were surveys of varying quality. The key papers used were sorted into topic areas and are presented in summary form in Appendix 4 grouped by topic: (1) Context of care, (2) CAM, (3) Manual therapies, (4) Osteopathy, (5) Satisfaction, and (6) Expectation.

The literature revealed that satisfaction has been used in the concept of healthcare for more than 50 years; the first documented study of patient satisfaction was listed on Pub Med in 1926 (McArthur, 1926). There has been a steady increase in studies in this area and by the beginning of 2009; a total of 2199 studies had been published looking at various aspects of patient satisfaction. The impetus for developing patient-focussed studies originally began in the 1970's principally in the United States of America (USA); this occurred due to

government support and an increased interest in the quality of medical care (Ware and Snyder, 1973). The Griffiths report (1983) encouraged the role of the consumer as a legitimate judge of quality and called for measurement of levels of satisfaction through patient surveys (Croft et al., 1993; Magni et al., 1993). There has been an increased shift in consumerism and a consumer-orientated culture in healthcare in the interests of maintaining a competitive edge (McIver, 1991a and b); the term consumer has increasingly appeared in UK patient satisfaction literature (Hopkins, 1990; Williams and Calnan, 1991a; Cox et al., 1993; Hudak, 2003).

The study of patient expectations began earlier than satisfaction with the first cited paper on patient expectation published in 1877; this related to the experience and expectation of clinical research. The early studies of expectation, between 1877 and the early 1960's, focused on life expectation. The role of psychological research is evident from the mid 1960s where the notion of locus of control is first considered in relation to expectation (Feather, 1967; Copp, 1971). Research by professional groups investigating expectation from the stance of clinicians and patients began to be documented from the 1970s (Andreassen et al., 1974; Noyes, 1974). This review therefore considered papers from 1970 onwards. The development and growth of patient-centred healthcare policy is, in part, responsible for the growth in studies examining patient expectation.

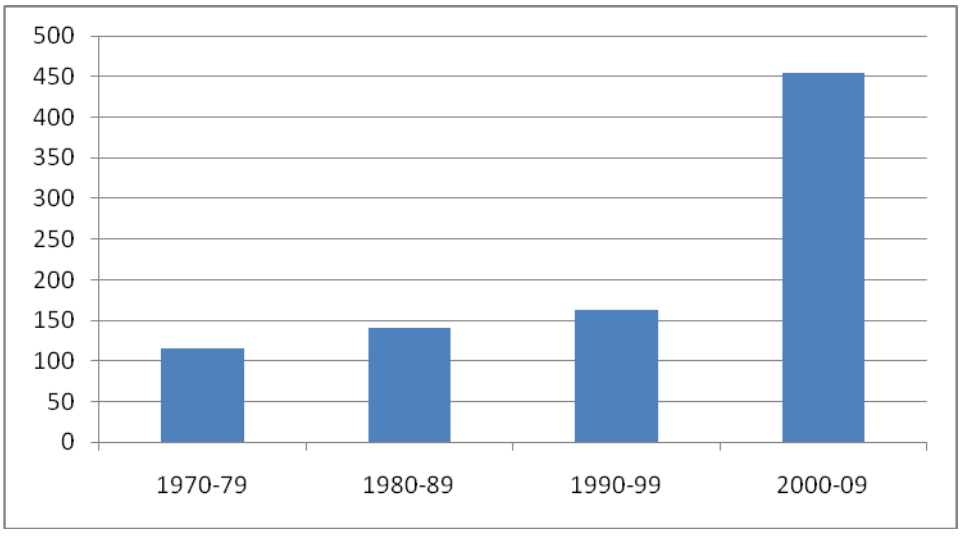


Figure 2.1 Number of Pub Med listed studies on patient expectation between 1970 and 2009

2.4 Definitions of Expectation

Patient expectation has been defined in a number of ways. It is the anticipation of something happening, a confident or strong belief that a particular event will happen, a notion of something in the form of a strong mental image which may or may not match reality, or, perhaps most pertinently, it is a standard of performance expected by or of somebody (Chambers, 1996). Satisfaction as a construct is intrinsically related to expectation. It can have a variety of meanings depending upon the context in which it is used (Linn, 1975; McCracken et al., 1997). It can mean contentment, fulfilment of one's wishes, expectations or needs, or the pleasure derived from this, when used as a mass noun (Chambers, 1996; Oxford, 1998).

The clear identification of patients' expectations within their contextual framework is becoming an increasingly important aspect of healthcare for ethical, commercial and legal reasons (Abramowitz et al., 1987).

Expectations are an integral part of the psychosocial makeup of each individual patient; a set of beliefs, created and sustained by a cognitive process (Barron, 2007). They have been defined as pre-trial beliefs that serve as a standard for judging subsequent performance; as predictors of what *will* occur, or as standards users believe a service *should* offer (Olsen and Dover, 1979; Oliver, 1980). Describing expectations in healthcare as "formulated by clients or patients about the services they think

(1995) proposed four types of expectation:

Ideal: an aspiration, desire, want or preferred outcome, which matches the user's belief about the potential for a service.

Predicted: the realistic, practical or anticipated outcome, which matches what the user actually believes will happen.

Normative: what should or ought to happen based on what users are told or led to believe.

Unformed: users do not have any particular expectations, for example new users may not have sufficient experience or knowledge to formulate specific expectations. Others

may find their expectations too difficult to express for some reason, for example fear, anxiety, conforming to social norms.

Prakash (1984) further conceptualised patient expectation of care as having two aspects:

- What patients expect as a result of their own or others' experiences (normative/comparative expectations)
- What care they would like and/or hope for (idealised expectation)

Crow et al., (1999) defined expectancies as:

- treatment-related outcome expectations - beliefs that treatments will have a negative or positive effect on health status
- patient-related self-efficacy expectations – beliefs that one can carry out the actions necessary for successful management of a disease or coping with the treatment

Five types of expectancy were identified from this definition:

- Process expectancy
- Positive outcome expectancy
- Negative outcome expectancy
- Interaction self-efficacy
- Management self-efficacy

Crow et al., (1999) also looked at the effect each of these types of expectancy had on preparation for medical procedures, management of illness, and treatment outcomes. They concluded that expectancies are an important part of the mechanism by which placebos have their effects.

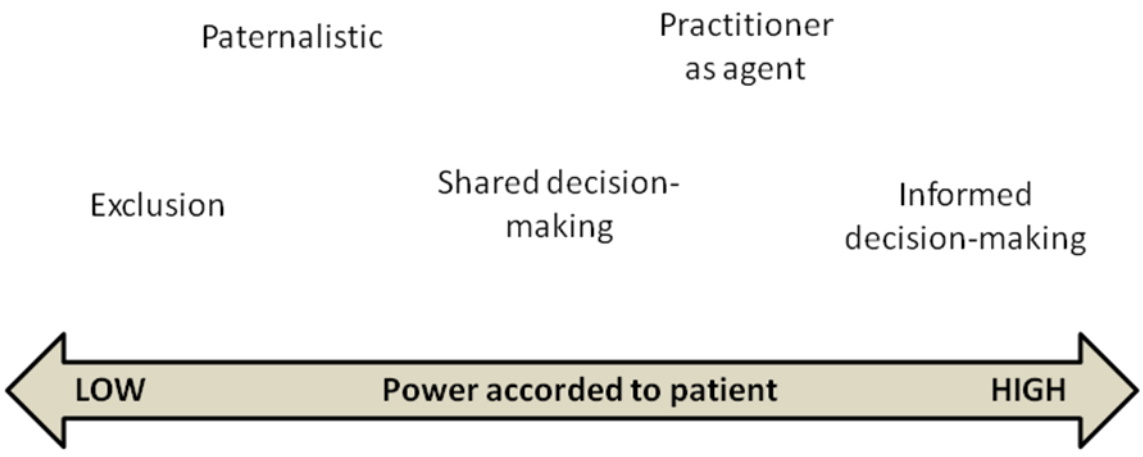
When trying to determine "What is expectation?" Janzen et al., (2006) noted that in psychological literature, the term "expectancy" is used to identify the general concepts, while "expectation" is used to identify specific examples of expectancy in real world settings. Despite the volume of research, very little literature, with the exception of the work of Thompson and Sunol (1995) and Olson (1979), proposed either psychological frameworks or pragmatic models to explain attitudinal and behavioural manifestations of health.

2.5 Theory and models of patient expectations of healthcare

Expectation is a broad construct based on many variables including (patient) self and therapist belief (Block et al., 1976; Davies, 1981), diagnostic factors (Monahan, 1977), patient attitude (Weinstein, 1979), and other psychological factors such as hopelessness, control and treatment dropout (Zarit, 1980).

Thompson (2007) described five prevailing models of patient involvement in care and the consequent shift in the balance of power (Figure 2.2): *paternalism* (involvement limited to receiving information or giving consent); *shared decision-making* (options are shared between patient and practitioner); *practitioner-as-agent* (practitioner holds technical expertise, but patient preferences are incorporated into decision-making); *informed decision-making* (technical expertise transferred to patient who makes the final decision).

Figure 2.2 A power continuum within healthcare consultations
(adapted from Thompson 2007)



Such notions have proved challenging to established NHS culture, with "recognition of the patient as a stakeholder rather than a grateful recipient in the provision of healthcare" (Arnold, 2004, page 187) requiring adjustment to both the process and environment of service delivery. There is a contrast between NHS and private sector healthcare; "Patient power should be no more problematic within an NHS system than it is in a system of health provision in which the patient is a paying client" (Arnold, 2004, page 189). In a competitive market place it is imperative for private sector practitioners to retain existing clients and recruit new ones. Since word-of-mouth recommendation is an important source of self-referral for fee-paying clients (Potter et al., 2003), failure to recognise their power as stakeholders and the potential impact on their ideal, predicted or normative expectations, could have implications for business success.

Patient-practitioner perspectives

The extent of congruence or divergence (gaps) between user expectations of a service and providers' perceptions of those expectations is the focus of a range of conceptually similar theories, exemplified by the Gap Model for managing quality (Parasuraman et al., 1987; O'Connor et al., 2000; Davis, 2003; LaVelle, 2004). The Gap Model describes five gaps:

Gap 1: Service providers do not understand the needs and desires of their customers, for example patients expect a 10 minute wait, but management believe they expect to wait 20 minutes.

Gap 2: Service providers' perceptions of quality do not match organisations' specification for service delivery for example, resource allocations are insufficient to deliver the service.

Gap 3: Organisational guidelines do not match the service delivered because employees deviate from the guidelines.

Gap 4: Consumers' expectations are raised, for example in promotional literature, but not fulfilled – "Don't promise what cannot be delivered".

Gap 5: there is a discrepancy between consumers' expectations for the service and their perceptions of the service, for example patients perceive waiting times to be longer than they actually are.

Gap 1 is the most crucial in terms of the rest of the model, and may be large if a healthcare organisation focuses mainly on operations and transactions rather than on consumer relationships; an organisation needs to have an accurate awareness of consumer expectations of service quality. Without this, Gaps 2-4 cannot be adequately closed. (O'Connor et al., 2003)

The priority given to various expectations can differ between practitioners and patients. This dissonance can be at the heart of dissatisfaction, poor outcome and compliance (Atiba, 1993; Peck, 2004; Esposito, 2005). For example, in a study of 36 chiropractors and 336 new patients from 17 private practices in Sweden, patients' expectations differed from those of the chiropractors. Patients had lower expectations of the treatment than the chiropractors, but higher expectations of being given advice and exercises. They also expected to get better faster than the chiropractors expected them to.

There has been some debate as to whether 'technical' interventions such as tests, medications and non-drug therapy, or 'non-technical' interventions such as education, stress counselling, negotiation and provider 'humanism' are the more significant indicators of satisfaction in terms of unmet expectations (Froelich and Welch, 1996; Peck et al., 2001). When identifying physiotherapist (n=37) and patient (n=26) expectations in private practice physiotherapy, Potter et al., *(*2003) found that physiotherapists attributed more importance to the way they behaved with patients:- providing professional and ethical care, active listening, being caring and empathetic. But patients ranked the nature of the treatment provided- symptomatic relief, self-management strategies and 'hands-on' treatment- as more important.

A range of specific expectations of the clinical encounter is reported across health care contexts and disciplines, for example chiropractic, general practice, hospital medicine, nursing, and physiotherapy. These include appropriate waiting times, diagnostic certainty, based on appropriate testing; physical examination; timely and sufficient information and instructions (including self-management); symptom relief; referral to specialists; sickness certification; a knowledgeable professional who communicates well; a relationship based on

trust, understanding, listening, and being included in decision-making (Kravitz et al., 1996; LaVelle, 2004; Verbeek et al., 2004; Llewellyn et al., 2005). Osteopathy may include similar dimensions of care to physiotherapy. Hills and Kitchen (2007) suggested that these dimensions of care are similar to those suggested by Donabedian's framework components for healthcare evaluation (1966, 1988). These include:

- Structure – the settings in which care occurs including facilities, equipment, staffing levels and organisation
- Process – what is actually done in giving and receiving care from the perspective of both patients' and practitioners' activities
- Outcome – the effects on the health status of patients and populations

Donabedian (1988) further distinguished between technical and interpersonal elements of care. The quality of the technical performance is judged in comparison with best practice and can be equated with effectiveness. The interpersonal process is the means though which technical care is delivered. Stimson and Webb (1975) also described the expectations that patients have about their care in terms of their background, the interaction with their healthcare practitioner, and their expectations of what actions will take place during a consultation. Carr-Hill (1992) further proposed that patients may not only have expectations about what will happen during a consultation, but also how it will happen. This is in contrast to the findings of Payton et al., (1998) who found that many patients had no clear idea what physiotherapy involved, and had no expectations of treatment or of the physiotherapist's role. Roush and Sonstroem (1999) sought to explain this by the fact that the physiotherapy encounter is much less known about than that with a medical practitioner.

Halstead (1989) described the role of confirmation/disconfirmation in healthcare delivery. This is the relationship between a person's comparison of an initial expectation and actual performance. Confirmation occurs when expectations are confirmed by performance; and disconfirmation occurs when discrepancies occur between expectancy and performance.

A number of key elements have been identified as representing a minimal level of care for patients. These have been described as active and passive processes (Small, 2007) within the secondary care setting. Active processes include ease of access to treatment and the therapeutic environment (Epstein et al., 2004), the availability of suitable appointment times

(Young, 1996), the thoroughness of the consultation including case history-taking and examination (El Nemer et al., 2005), and the explanations given and how they support or contradict earlier information received (Walsh, 1995; Welsh, 2001). The passive processes focus on the provision of ethical care, active listening, and being caring and empathic (Potter et al., 2003). These features were found to be important to both therapist and patient but, on balance, patients placed greater emphasis on the provision of hands-on treatment and the potential for symptomatic relief (Vincent and Furnham, 1995). These ideals concur with the processes involved in the conceptual framework proposed by Donabedian (1988). Carr-Hill (1992) further elaborated that patients not only have clear expectations of treatment and management strategies, but how and when that treatment will be delivered.

The formation of patient expectations

Robinson et al., (2005) described the multidimensional success criteria and expectations for treatment from a study of chronic pain patients in secondary care. This is represented diagrammatically below.

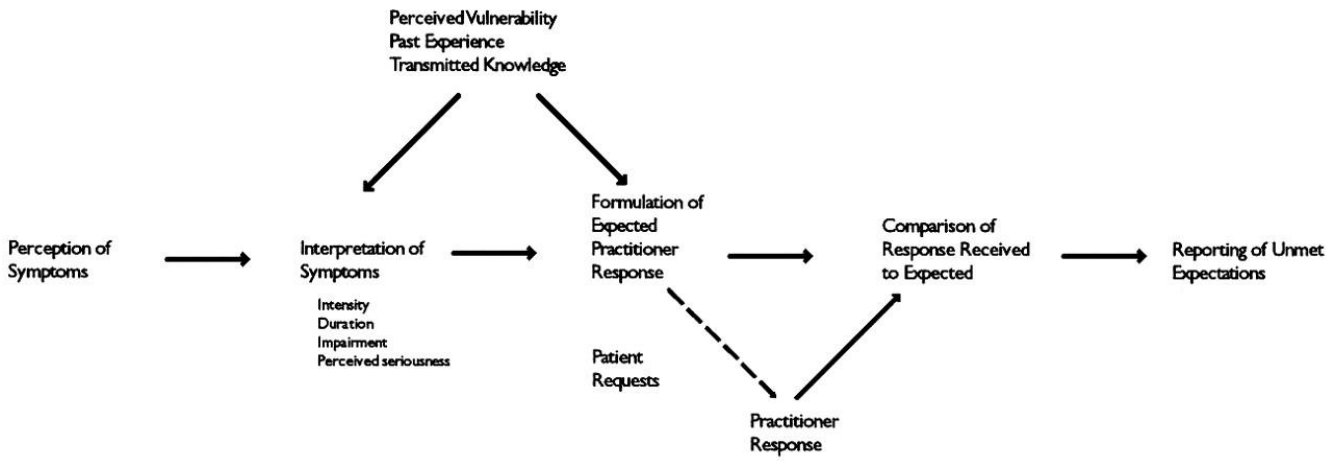


Figure 2.3 A preliminary model of how patients develop and report expectations.

Perceived vulnerability, past experience, and transmitted knowledge influence expectations both by affecting the interpretation of symptoms and by establishing an implicit standard of

care. The behaviour of health care practitioners is then evaluated in the light of these expectations.

Quality service is a long-term reality that directly affects patient care, patient outcome and practice success. Brown et al., *(*1993) investigated the concepts of service quality through interviews with physicians in single and multiple practices according to the following criteria of service and the consideration of "whose needs do come first within your practice?" to identify the personal beliefs of therapists concerning what constitutes good service. The criteria identified are quite transferable to osteopathic practice and included telephone answering, scheduling of appointments, convenience of practice location, comfort of environment, dignity, parking, interaction, quality of care, follow up, and referral. Brown et al., (1993) attempted to model the relationship between patient satisfaction and expectations, using the "quality diamond" taken from the business literature. This is shown in Figure 2.4.

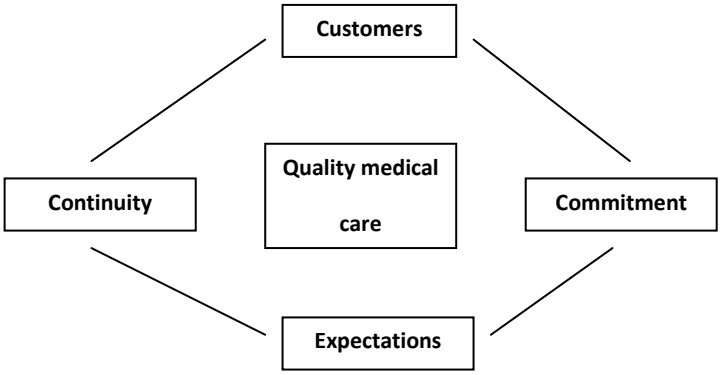


Figure 2.4 The quality diamond.

Brown et al., (1993) further encapsulated the concept of meeting patient expectations and delivering patient satisfaction in the equation:

Clinical quality + service quality = patient satisfaction

2.6 Patient factors influencing expectation

Influence of ethnicity and culture on expectations

As described earlier, expectations of healthcare are influenced by individuals' experiences, understandings, judgment, and circumstances, which shape their beliefs and attitudes. Similarly, shared beliefs, attitudes, and experiences within ethnic groups may shape normative and ideal expectations. Shared culture may also be a factor in influencing expectations. For example, psychological studies suggest that people from cultures that emphasise feeling good make less critical judgements of experiences than those from cultures that put a premium on achievement (Dayton et al., 2006).

Studies have shown both differences and similarities in health/illness beliefs and expectations between ethnic groups as well as between individuals within those groups (Donovan, 1986; Howlett et al., 1992; Morgan, 1996). Social forces may mould differences to some extent. For example, comparing the meaning of high blood pressure between people of Afro-Caribbean origin and White Caucasians, Morgan (1996) observed that differences varied according to length of residence, common experience of the healthcare system and socioeconomic position. When examining the impact of ethnic grouping on the experience and expectations of care in UK General Practice, Ogden and Jain (2005) reported no differences between Black African, Black Caribbean and White British patients' expectations of good communication, wanting the GP to focus on the patient's agenda, and a desire to make choices about how their problems were managed. It should also be borne in mind that diversity is broadened by the evolving culture of younger generations. Bhugra and Bhui (1997) found that Britain's Black communities regard the UK as their home and do not see themselves as immigrants; the use of migration-related models of cross-cultural assessment and management is now less helpful (Bhugra and Bhui, 1997).

Training in cultural awareness and sensitivities may be lacking in the educational curricula of many healthcare professionals resulting in dissatisfaction with care, lack of compliance and inappropriate usage of medical resources (Ware & Davies, 1983; Bobo et al., 1991; Mull, 1993; Rothschild, 1998; Jackson and Kroenke, 2001). Previous studies have suggested that

physicians consider immigrant patients to be more demanding, difficult to understand and to have greater expectations than native-born patients (Brod and Heurtin-Roberts, 1992; Favrat et al., 1994; Tocher and Larson, 1999).

Perron et al., (2003) investigated the differences in expectations of healthcare professionals and their perceived expectations of Swiss nationals and immigrants mainly from southern Europe, the former Yugoslavia and Africa. Pre-consultation patient surveys were matched with post-consultation physician surveys to investigate the degree of concordance. They found that most patients hoped for reassurance, physical examination, diagnosis, counselling, information about prognosis and medication. More technical expectations such as desire for investigations and referral to a specialist were present but to a lesser extent. Poor agreement was found with physicians' expectations who underestimated both native and immigrant patients' expectations for counselling, investigations and referral to a specialist. The study also identified that ethnic minority groups and immigrant patients do not systematically make heavier demands on physicians or health systems, contrary to physicians' assumptions (Carne, 1970; Gillam, 1987; Favrat et al., 1994). Physicians in the study were found to have a poor awareness of their patients' expectations, regardless of their patients' origin. Kravitz et al., (1997) found that non-white patients in the US reported more expectations in questionnaires but fewer during interview.

Further work has taken place in Sweden looking particularly at the cultural effects of pain. In Sweden approximately 11% of the population are born outside of the country. The study considered the work of Zborowski (1969) who studied differences in the expression of pain among four distinct ethnic groups: Irish, Italian, Jewish and old American (native-born Anglo-Saxon). Interethnic differences between pain related variables have been investigated clinically and experimentally (Lipton et al., 1984; Thomas and Rose, 1991; Sanders, 1992; Bates et al., 1993; Faucett, 1994; Edwards et al., 2001). Bates noted that attitudes and degree of attention to pain affected the perception of severity; this was most marked in patients from Hispanic backgrounds.

Brod and Heurtin-Roberts (1992); Favrat et al., (1994); and Tocher and Larson (1999) identified that therapists expected immigrant patients to be more demanding and have greater

expectations of care. This view however, has been largely rebutted by the work of Perron et al., (2003) and Bhugra and Bhui (1997) who found that immigrants had no greater expectations of healthcare provision that a country's natural-born resident. This suggests that models of cross-cultural assessment when trying to identify expectations are now less valuable.

Age and expectation

Expectation has been considered a non-specific factor in treatment (Frank, 1961; Goldfried, 1980), a necessary element of treatment induction (Hoehn-Saric et al., 1964; Orne and Wilder, 1968), a critical but changing factor in treatment (Tollinton, 1973), as well as a construct related to a host of other demographic and treatment factors (Bowden et al., 1980). Most often, however, it related to treatment outcome.

Age has been alluded to, but has largely been ignored for its role in expectations or any meaningful investigation (Steuer, 1982; Storandt, 1983). Langer et al., (1979) and Gallacher and Thompson (1983) noted that in elderly populations, control over treatment had a positive relationship with outcomes. Other psychological factors, particularly hopelessness, values, locus of control, and self-concept were also implicated in expectations of care (Sherman, 1981; Hussian, 1982). Hyer and Collins (1986) investigated such treatment expectations in a veterans' medical centre, looking at the post-hospital adjustment of psychiatric patients. They found a highly significant correlation between treatment expectations rising with age. Other characteristics were examined for their influence on expectation as it varies with age. Diagnosis, marital status, educational background, duration of symptoms, and employment during the past 5 years were also found to be important. Education and a long history of previous symptoms were found to have the most significant effect on expectation. Layne (1980) also identified that motivation and goal-setting were important factors intricately linked with expectation. Wetzels et al., (2007) also concurred that patients expected to be involved in the delivery of medical care even at advancing age, and encouragement of this involvement resulted in more favourable outcomes in terms of physiological and functional status.

Rutsihauser et al., (2003) examined expectations at the other end of the age spectrum and investigated the gap between expectation and experience for adolescents' consultations. A parent or guardian was commonly present during a consultation, but being able to see a

therapist alone, and the reassurance of knowing that imparted information would be kept confidential, were key expectations. This represents a practical challenge to therapists where the law is quite clear on the need, ordinarily, for a child to be accompanied if less than 16 years of age (General Osteopathic Council, Fitness to Practise, 2005). The notion of Gillick competence in the decision-making process relating to treatment and disclosure of information supports this expectation (Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402 (HL). Gillick competence is a term used in medical law and originating in England. It is used to decide whether a child aged 16 years or younger is able to give consent to his/her treatment and without the need for a parent's knowledge or permission.

A lack of understanding of the developmental aspects of adolescents was identified by Veit et al., (1995) as producing a feeling of discomfort in many therapists when treating adolescents. A lack of education of physicians in this area was also identified by Stronski et al., (1999). Compliance with treatment and returning for treatment were strongly associated with the assurance of unconditional confidentiality (Ford et al., 1997). There may be difficulty in complying with this requirement in the context of legal and ethical constraints. The opportunity to have time alone with a therapist was cited as particularly important for females rather than males; similarly it was more important for girls to see a therapist of the same gender (Rutishauser et al., 2003). Short waiting times were rated as highly important among adolescents of both genders, but offering evening sessions was not viewed as important. Additional factors in this age group include psychosocial history, including family life, peer relationships, recreational activities, school performance and vocational goals and concurrent depression and risk-taking behaviours.

Tsao et al., (2005) explored the expectations of children with a mean age of 13.8 years, with chronic paediatric pain and their parents in relation to complementary and alternative medicine (CAM). A variety of CAM treatments including hypnosis, massage, yoga, acupuncture, and relaxation were compared with allopathic interventions including medication and surgery. Parents expected most of the available treatments, with the exception of surgery, to be helpful in the relief of symptoms. In contrast children expected medication and relaxation to be more helpful. Parents' expectations were regarded as significant, not solely from a financial standpoint and the decision to seek CAM as a form of

care, but also because of the effect on compliance and attrition rates (Day et al., 1980; Yeh et al., 1999; Kemper et al., 2000; Richardson, 2004). The children expected the benefits of CAM to be lower than their parents. Tambiah (1990) and Kaptchuk (2002) maintained that CAM modalities may involve a high level of "performative efficacy" which relies upon the power of belief, meaning, expectation and persuasion. Cho et al., (2005) discusses expectation theory in terms of patients' beliefs and expectancies regarding a positive outcome, asserting that they could trigger a placebo response (Wolf, 1959; Papakostas et al., 2001).

The incidence of prescription based on the meeting parental expectations was investigated by Mangione-Smith et al., (1999). Expectations were assessed pre- and post-consultation and it was found that parental expectation was the key indicator for prescription 62% of the time versus 7% of the time when it was thought that patients didn't expect a prescription. This perception also influenced the diagnosis made by the clinician, which attempted to support the prescription in the absence of clinical indicators. When parents were surveyed, communication issues were found to influence satisfaction, rather than prescription. Surprisingly, drugs being prescribed can follow a pattern of prescribing to meet perceived parental expectations and promote satisfaction, even in the knowledge of challenges to public health. Patterns of prescribing of antimicrobial medication were investigated by Mangione-Smith et al., (1999). The growth in antimicrobial resistance through inappropriate prescribing is increasing in the United States even though it is known to increase morbidity and mortality, and health costs (Cohen, 1992; Schappert, 1997).

Older patients were generally more likely to express satisfaction than younger ones (Locker and Dunt, 1978; Fitzpatrick, 1984). Older female patients especially had specific expectations including communication, systems-based practice, and professionalism. Diverse communication barriers were cited including the use of medical jargon, inadequate information about illnesses, and lack of openness when discussing sensitive topics. Consistent information, respectful treatment, clear and understandable language, and an awareness of the patient's resources have also been identified (Houle et al., 2007).

The effect of prior experience

Patients are likely to have consulted their GP before seeking osteopathic treatment or any other forms of CAM therapies (Vincent, 1996). They may have been given a diagnosis, be taking medication or have received other forms of treatment e.g. physiotherapy: they may have tried a selection of CAM therapies before seeking an osteopath. Patients of GPs tend to have suffered their complaints for the shortest time, while those receiving acupuncture have suffered the longest. In the study by Vincent et al., (1996), the osteopathic patients are in second place compared to GP patients in terms of having had their complaint for a short time. The authors propose that this shows that patients turn to CAM when allopathic medicine has failed them and they turn to more marginalised forms of CAM the longer they have their complaint. The osteopathy-specific data suggests that patients have similar expectations of their osteopath as they do for their GP. They may expect both types of practitioners to provide an effective, quick resolution to their symptoms. Further study of osteopathic patients specifically will increase understanding of this issue.

Motivation for seeking treatment

Patients' experience of, and feelings towards, allopathic medicine may assist understanding of patient expectations within osteopathy. Various areas of dissatisfaction with allopathic medicine have been shown. These include a general dissatisfaction with treatment and scepticism of its efficacy (Furnham et al., 1995), a dislike of practitioners' attitudes (Lazar, 1997) and dissatisfaction with the GP–patient relationship (O'Callaghan, 2003). More significantly, perhaps, were the findings that allopathic medicine had not been effective (Lazar, 1997; Sirois, 2002).

The expectations of vulnerable patients and their carers

Redman (2007) asserts that all consumers in healthcare are vulnerable simply by having the need to enter the healthcare system. Patients trust and rely upon healthcare providers to deliver the best care available: safe, effective, and ethical. Vulnerable groups include infants and young children, prisoners, and the cognitively impaired or mentally disabled. It is becoming increasingly appropriate to include elderly populations in this classification. Vulnerable groups often experience disparities in the health care they receive. Greenberg et

al., (1999) explored the expectations of siblings of being involved in the care of relatives with mental illness or mental disability diagnosed from birth or early childhood, unfortunately termed "mental retardation" in the paper. Almost 60% of siblings of adults with mental disability expected to be involved in their future care. However, only one third of siblings of adults with mental illness expected to be involved in their care. The need for practitioners to be able to communicate adequately with both adult and carer is likely to increase as the population demographics change and healthcare provision ensures that more babies survive to term and the trauma related to delivery.

Carers of patients will also experience expectations which may be at variance to those of the patients in their care (Gwyther, 1994; Speice et al., 2000). Family members in particular may hold ideal expectations (Kilbourne et al., 2001). If these are not met, considerable stress can result (Kristjanson et al., 1997). Caregivers would expect support from healthcare professionals in this setting (Wenman-Larson and Tishelman, 2002).

Socioeconomic factors

Melzer et al., (2000) looked at socioeconomic status and the expectation of disability in older age; a variety of measures were used including Sullivan's method (Jagger, 1999), and the modified Townsend disability scale (Bond and Carstairs, 1982) in combination with fieldwork interviews. Higher levels of disability and expectation of disability were found in women than men, especially in lower socio-economic groups, but differences men and women reduced in very old age groups (85-89). Higher socio-economic groups expected lower levels of disability. Socioeconomic differences are one of the key influences on health and their effect on mortality in old age is well established (Fried and Guralnick, 1997). Stuck et al., (1999) identified that the prevalence of disability in relatively privileged sections of the population are lower.

2.7 The influence of healthcare context on expectations

Context is used here to include aspects of the process and organisation of services providing care.

Expectation and environment

O'Connor et al., (2000) found that clinic employees including administrators and physicians underestimated their patients' expectations for service reliability (ability to perform promised service dependably and accurately), assurance, knowledge and courtesy of employees and the ability to convey trust and confidence, responsiveness (willingness to help customers and provide prompt service) and empathy (caring and individualised attention), but overestimated the tangibles (physical facility, equipment and appearance of personnel). Zeithaml et al., (1990) believed that reliability may act as a precursor to how the other four dimensions are evaluated.

Observers and trainees

The presence of students and other staff in training at both graduate and undergraduate levels was also discussed by O'Flynn (1997) and Larsen (2006). Patients expected to have students present when physical complaints were being discussed, but not when the discussion of emotional problems or internal examinations were a feature of their consultation. Young women also did not expect male students to be present during examinations (Kljakovic, 2002). The majority of patients, however, found the experience personally rewarding (Stacy, 1999; Coleman, 2002; Walters, 2003).

Primary care

Parsons et al., (2007) specifically investigated patients' expectations of care in a primary care setting. A systematic review of qualitative studies was undertaken and the findings were very positive. Patients were generally pleased with their GPs' skills. Gannick and Jesperson, (1984) viewed the GPs long term knowledge of their situation as more valuable than a specialist referral (Rogers, 1999). The ability to engage in a therapeutic relationship with their GP was important (Johansson et al., 1999) but patients recognised that there were limits to that involvement (Johansson et al., 1996).

Patients define success in a therapeutic setting in a different manner to healthcare professionals (Salisbury, 1997; Neuberger, 1998). Out-of-hours contact in the NHS is now organised through a variety of mechanisms, rather than the previous GP contracts for the Department of Health. These aim to avoid fatigue, inappropriate calls and threats to personal

safety. Quantitative research has focussed on identifying expectations and the extent to which they have been met. Key expectations have focussed on the "manner" of the healthcare professional, closely followed by the explanation and advice received. Other factors which have been shown to be important are the perceived length of time taken to return a call, and the nature of the initial contact when an out-of-hours call had been made. The study found that advice offered by reception staff was viewed less favourably than when offered by healthcare professionals (Thompson and Farrell, 2004).

Patients increasingly approach primary care settings with expectations that their needs will not be met due to the pressure on spending (Levinson et al., 2005; Keitz et al., 2007). In the US, request for treatment or other interventions are not met 12-30% of the time (Brody et al., 1989; Kravitz et al., 1996; Marple et al., 1997; Bell et al., 2002; Kravitz et al., 2003; Peck et al., 2004). Keitz et al., (2007) investigated how pre-visit expectations were fulfilled during a consultation; direct requests were made by patients in 40.6% of consultations and these requests were frequently fulfilled (77.7%). When direct requests were not met, alternatives were negotiated and offered; patients accepted this alternative when the rationale was clearly explained. In this way unmet expectations did not affect patient satisfaction.

Buetow (1995) examined general practice in Australia and looked at dimensions of care, building on the work of Penchansky and Thomas (1981) who had previously cited accessibility to care as having five dimensions:

- Availability – the difference between rural and urban settings and the distribution of doctors within those areas
- Geographic access – the distance to cover, the travel time and the adequacy of transportation
- Accommodation – organisation of resources and the delivery of care via appointment systems, waiting times, hours of operation and telephone services
- Affordability – care is free at the point of contact
- Acceptability – attitudes of the patients to the doctors and the practice staff, and to the medical facility in which care is offered, and of both groups to the care system

These dimensions permit comparison of the needs for, and access to, care among patients with different social, economic and cultural groups and similar health problems. Cartwright et al., (1990) investigated appointment times specifically: morning and afternoon sessions

met most people's needs but working patients expected to be able to come in their free time. Most patients wanted routine appointments at weekends. Receptionists could influence patients' choices of appointment times. Arber and Sawyer (1985) found that young people and those with children were more likely to report interaction difficulties.

Redsell et al., (2007) examined the effect of change in first contact care in general practice and the expectations of nurse consultations. Little knowledge or experience concerning nurse consultations was available producing a paucity of information on which to base expectations. Satisfaction with GP consultations were noted as patients knew what to expect. Difficulty in articulating pre-consultation expectations was noted when investigating nurse-led care.

Access to treatment

The changing dynamics of working practices and family life has manifest in differing expectations of access to treatment. Convenience of access has been emphasised by highly mobile patients with multiple work and family demands. Traditional healthcare providers cite one of the benefits of their model as the continuity of care offered to patients (Rizo et al., 1990; Borkenhagen, 1996). Belle Brown et al., (2002) undertook a qualitative study looking at patients' expectations of this type of service. The findings emphasised the mindset of convenience which has become a societal expectation; in the eyes of many, healthcare should be as convenient as fast food outlets. This was summed up by one interviewee "Bottom line is it's a service. People want a convenient service". Several focus groups used McDonalds as an analogy. This was compared with the dissonance which exists between patients' expectations and the obligation of a healthcare system or healthcare professional to provide convenient care, and what a patient has a right to expect. Some participants cited the lack of family support immediately available as increasing their reliance upon, and expectations of, healthcare professionals. The lack of continuity of care was cited by patients, but many felt that this was an acceptable price to pay for the increased convenience of greater access (Katz, 1983; Bell et al., 1992; Osmun, 1994).

Secondary Care

Primary care and secondary care patients have different expectations of their environment. Small et al., (2007) identified cleanliness and the state of the décor as important in secondary care. A distinction was also drawn between "hard" and "soft" aspects of rehabilitative care (Young, 1996). Hard aspects of care concerned hands-on treatment e.g. exercise and therapy; soft aspects of care included listening and counselling. This was further conceptualised into "technical" and "human touch" (El Nemer et al., 2005).

Thompson and Farrell (2004) found that key expectations in both primary and secondary care focussed on the "manner" of the healthcare professional; this was closely followed by the explanation and advice offered and who exactly was providing that advice within the staff hierarchy (Small et al., 2007). Levinson et al., (2005) identified that although these expectations are explicit, patients increasingly believe that their expectations will not be met due to pressures on spending.

Although common expectations were identified in secondary care, i.e. staff communication with patients, appropriate waiting times, the triage process, information management, quality of care, and improvement to existing services, high levels of satisfaction were evident (Peck and Ash, 2001). Work undertaken by Hansagi (1992); Bursch (1993); Krishel (1993); Brown and Sheehan (1995); Yarnold (1998); Boudreaux (2000); and Trout (2000) identified several predictors of satisfaction including a higher patient acuity level, effective staff communication, and a caring bedside manner. Satisfaction was found to be affected by perceived rather than actual waiting times (Thompson and Yarnold, 1995; Thompson and Yarnold, 1996). Patients rated the importance of kindness and compassion, explanation of results and illness, and speed of care more highly than the nurses rated these factors (Hostutler, 1999). Several patients expressed the view that when attending for treatment, they are often frightened, in pain, and anxious. They expected to be treated as individuals, be provided with reassurance, and have staff listen to their concerns. Staff were not expected to stand around, ignoring patients, and engage in personal conversations within the earshot of patients (Watt, 2005).

Emergency care

Quality is a vitally important focus of emergency medicine and patient-centred care is a priority (Committee on Quality of Care, 2001); meeting of community needs and expectations is particularly important (Cone, 2002). Welsh (2001) focussed on expectations in emergency care settings and identified that users perceived the purpose of such a visit to include assessment, diagnosis, treatment and advice. Patients were further asked about what they expected personally in terms of outcome. These included provision of treatment, assessment or examination, diagnosis, "Help make it better", an x-ray, reassurance, advice or explanation, quick, prompt or efficient attention, and provision of pain relief. Sources of dissatisfaction were due to the attitude of staff, waiting times, missed diagnoses, incorrect or delayed treatment, and lack of information. Complaints centred on the accuracy of the diagnosis or treatment, waiting times, the attitude of staff, and a lack of explicit care.

Expectations of care within complementary and alternative medicine (CAM)

There is a great wealth of literature concerning the health beliefs, experiences and behaviours of users of complementary and alternative medicine (CAM). Whilst not explicitly investigating patient expectation, it does reveal implicit expectations of care. Most studies either examine users of CAM as a generic group or compare and contrast users of osteopathy, acupuncture and homeopathy.

In focusing upon health beliefs, experiences and behaviour, these studies shed important light upon the demographic and sociological background of patients that may seek out osteopathic treatment. Findings are not always congruent. While one study presents users in a negative light – as tending to suffer from chronic conditions, having lower perceptions of quality of life and having greater levels of anxiety and depression (Kersnik, 2000), others present them more positively. One study found CAM users to be less fatalistic regarding health, more open and responsive to the role of psychosocial factors in health and displaying more ecologically-aware lifestyles (Furnham, 1996).

More importantly, perhaps, other studies have shown that CAM users are not a homogeneous group. There will be variety in medical histories; different therapies may attract different age groups and genders (Furnham et al., 1995). Other therapies will attract patients with different types of conditions: where patients seeking acupuncture and homeopathy tend to have a wide

range of conditions, those seeking osteopathy invariably present with musculoskeletal complaints (Vincent, 1996). The latter group were found to have had their conditions for a shorter period of time. If patients of different therapies have different conditions and have suffered for varying periods of time, they may well have different expectations of treatment that warrant investigation. Some initial investigation into the differing and specific attitudes of patients of osteopathy was presented within the same study. The side effects and dangers of allopathic medicine were not as much of a concern to the osteopathic patients. Availability of their treatment of choice was regarded of greater importance than it was for patients of acupuncturists and homeopaths. These differences in weighting the perceived disadvantages of allopathic medicine and the perceived advantages of CAM again warrant further investigation within osteopathy specifically.

Expectations of osteopathic care

There are a small number of studies which have looked at the area of patient expectation in relation to osteopathy. A questionnaire study of patients attending a student clinic found that expectations fell into five categories: information, outcome, professionalism, relationship and accessibility. When viewed generally using these categories, information was more important than outcome. However, when broken down to specific expectations, reduction of pain was the primary expectation with explanation of the diagnosis, and an understanding of the patient's problem held equal weighting for expectation.

Other studies confirm that patients come to osteopaths motivated by a belief that they are specialists offering effective, manual treatment that will find, explain and treat the cause of their symptoms (Fiske 2004). These beliefs and expectations are not specific to osteopathy: in a study of osteopathic patients who were asked 'why did you come to the clinic?' the main reasons stated were symptom-based. Patients do not have any specific expectations of osteopathy as opposed to other similar therapies. Indeed, some key elements of the consultation such as the requirement to remove clothing can come as a surprise to patients (Fricker 2008).

Osteopathic patients appear to concur with the findings of Yardley et al., (2001) in general practice that patients perceived physical realignment of the spine though HVLA to give

instant relief from pain; in osteopathy, patients favoured the manual nature of manipulation and judged it an appropriate treatment due to its manual nature (Westmoreland et al., 2006).

Work undertaken by Strutt et al., (2007) investigated satisfaction in a UK osteopathic training clinic. They found that four main themes were associated with the therapeutic relationship: hope, communication, respect, and trust. Two further themes emerged: one related to the environment of a teaching clinic; a second cross-checking theme described comparisons of the clinic with NHS services and other services.

The formation of expectations and perceptions has been found to be rooted in a lay referral system based upon the successful experience of family and friends and their consequent recommendation (Yardley et al., 2001; Fiske, 2004).

A small number of published studies have examined satisfaction, and to a lesser extent expectations, with osteopathic treatment. Two studies took place in the UK and two in America. Licciardone et al., (2002) undertook surveys of patients' views in ambulatory care settings, and also investigated patients' knowledge of osteopathy and the dimensions included in osteopathic care. A number of areas were covered in the survey on satisfaction which included continuity of care, access to convenient care settings and appointments, technical quality of the intervention, technical quality of the practitioner, and interpersonal manner of the osteopath. In his other work in this area, Licciardone et al., (2001) made similar findings to Hills et al., (2003) concerning patients' knowledge of what osteopathy would include and what its effects would be.

Expectations of chiropractic care

An in-depth questionnaire survey of 30 chiropractors and 336 patients compared the expectations of patients and practitioners. Chiropractic patients were surveyed by Sigrell (2001) who found that 'to get better' and 'to find the problem' consistently ranked highly in patients' expectations. Patients expected, in descending order of importance, to have their problem(s) explained to them, to feel better, to have the problem identified, and to be given advice and exercise. Only 67% of patients expected to be free of symptoms, with patients having lower expectations of treatment than the chiropractors. Sigrell (2002) investigated the association between expectation and satisfaction with chiropractic care. His study showed that the expectations of outcome was lower for the patient than the therapist, but the

expectation for advice and the prescription of exercises was higher among patients than therapists.

The effect of advertising

Direct-to-consumer-advertising (DTCA) has been studied for the effect it has on patients' expectations. Consumers feel that DTCA will enhance their relationship with healthcare professionals, but professionals report the opposite view. Many patients feel it meets their need for more information about their disease (Food and Drug Administration public hearing, 1995). Supporters of DTCA counter that it allows patients' expectations to be raised in a legitimate way by promoting access to new treatment developments, although patients with greater education may benefit more and gain a better chance of survival and success (Gelles, 1997). The main concern of physicians is that DTCA leads to patients being misinformed about the risks and benefits of many treatments, resulting in inappropriate management of their condition or symptoms (Law, 1998; Parker, 1998). Almasi et al., (2006) suggests this in turn can lead to inappropriate prescribing, and might induce a placebo effect that could increase the clinical effectiveness of the advertised product (Beecher, 1995; Kirsch, 1997; MacFarlane, 1997). Through the placebo effect, patients' positive expectations from DTCA could improve patient compliance and outcomes, and reduce the amount of treatment requested or required (Walach, 1999).

2.8 The influence of the therapeutic encounter on expectations

The therapeutic encounter is used here to include the consultation, examination, treatment, and advice on after care and self-management, as well as the therapeutic relationship with the practitioner.

Practitioner's attributes

In assessing the qualities of physiotherapists, nominal group techniques were used to explore the characteristics that are perceived to constitute a 'good' and 'bad' physiotherapist. These are the characteristics that it is assumed patients will expect from future practitioners. Effective communication was found to be the primary characteristic of a 'good' practitioner. This comprised interpersonal skills, manner, and information. Secondary to this

characteristic were those collectively cited as "other attributes" including professional behaviour, organisational ability and 'service provided'. The latter comprised diagnostic and treatment expertise, the therapeutic environment, and convenience/accessibility of treatment (Potter et al., 2003).

The increased expectations of patients, in terms of increased access to care, pose a challenge for healthcare professionals. The desire of the professional for a more balanced lifestyle and guaranteed income were discussed by Belle Brown et al., (2003). The desire for a guaranteed income may mean that professionals, particularly in the private sector, are booked a week in advance and may not offer the emergency appointments that patients desire; equally it was found that professionals "… would like to work 9-5, Monday to Friday and the rest of the time is theirs."

Epstein et al., (2004) noted that patients tend to notice the personal aspects of a clinical encounter . They notice when healthcare professionals are confident, whether they are attentive, caring, interested and present. They also observe whether a professional has noticed a patient's fundamental concerns. The use of open-ended questions was found to have mixed results, especially if they occurred early in a consultation. Although he concurred with the views of the work of the Picker Foundation (2003), that patients value their relationship with their healthcare professional, Epstein concluded that small things make a difference, even, for example, a receptionist who is more interested in their computer. Certain clinical habits of physicians promote communication: these include attentiveness, curiosity, flexibility and presence (Epstein, 1999; Epstein, 2003). Borrell-Carrio (2004) argued that informed flexibility and the ability to see a situation with new eyes can enhance communication and diagnostic accuracy.

The consultation

Clear expectations of the CAM consultation have been recorded. CAM practitioners are seen as more sympathetic, having more time to listen, being more sensitive to emotional issues and being better at explaining treatment and why a patient is ill (Furnham, 1995). The authors proposed that these factors and the general style of consultation appeal to the chronic patient perhaps more so than the nature of treatment. CAM is viewed as, and therefore presumably expected to be, more natural. Patients value the emphasis upon assessing and treating the

person. There is also high value placed upon the role of the patient in taking a more active part in their treatment and management (Vincent, 1996). O'Callaghan et al., (2003) suggested a cultural context describing the importance of post-modern values including a rejection of authority, an increase in consumerism, the importance of individual responsibility for health, the emphasis on nature and natural remedies, anti-scientific sentiments, and a holistic view of health. Subscription to post-modern values has been proposed as a significant predictor of a positive attitude to CAM and of its use (Siahpush, 1998). The post-modern desire for natural remedies which are regarded by some to be safer and more effective was of particular importance to the uptake of CAM. The rejection of authority was also proposed since CAM is viewed as allowing patients to have some input into their healthcare and participate actively in healing.

The pressure of expectation can influence consultations; MacFarlane et al., (1997) found that antibiotics were prescribed to patients who requested them in 22% of cases even though the clinical indication for prescription was placed at 1%. Dissatisfaction with the consultation and failure to fulfil expectations resulted in patients re-consulting twice as frequently. This effect was also demonstrated in an Australian study, but the prescription of medication was only three times more likely to occur to meet expectations (Cockburn, 1997). Studies of interventions in secondary care support this trend particularly in the field of obstetrics and gynaecology (Atiba et al., 1993; Peck et al., 2004; Esposito, 2005) and psychiatry (Schmid et al., 2004). This way of working has been criticised by many health researchers who counter that it would be better to spend time discovering exactly what patients expect from their treatment (Britten, 2004). The cost of inappropriate and unnecessary therapeutic and diagnostic interventions for the sake of maintaining a relationship with a patient is inadvisable and ultimately leads to poorer outcomes for the patient (Belle-Brown, 2003; Little et al., 2004).

Empathy and the clinical encounter

As a greater understanding of patient's expectations was gained, the concept of clinical empathy (CE) developed; this has been documented as influencing long-term outcomes for patients, and the general quality of a consultation. Empathy has been summarised by Carl Rogers as "the ability to sense a client's private world as if it were your own, but without losing the 'as if' quality" (Rogers, 1961). It can be differentiated from sympathy in terms of

being “a form of understanding, and a “value neutral” mode of observation; it should not be confused with attributes such as being nice, kind, compassionate or loving (Kohut, 1980).

In a clinical setting, empathy has been found to be a fundamental determinant of quality in medical care; it enables the clinician to enhance patient outcomes by fulfilling medical tasks more accurately. Studies in specific areas of secondary care:- homeopathic and acupuncture practice (Bikker et al., 2005; Price et al., 2006; Neumann et al., 2007) show patients value being treated as an individual, and being able to tell and have their "story" listened to in depth. Equality of relationship, mutual respect, and sharing decisions were also prominent themes (Mercer and Reilly, 2004).

An extension of the work on empathy has been to examine how it complements key components of the consultation process to allow the development of a patient-centred measure for this process. The development of the Consultation Quality Index (CQI) by Mercer and Howie (2006) attempted to identify the features of the consultation process that meet expectations and lead to favourable outcomes, in both the short and long term, through the acquisition of information and its application to self-management (termed ‘enablement’). They focussed on a series of items outlined by Donabedian. In common with Donabedian’s thinking, the CQI is composed of a process component (the consultation length), a structure component (continuity of care), and an outcome component (enablement). The CQI measures features of the consultation including the GP’s competence, the GP’s empathy or ‘caring’, being listened to by the doctor and having the opportunity to talk, being treated as an individual, the provision of a clear and understandable explanation, and the GP’s ability to see the bigger picture in terms of appreciating the psychosocial factors affecting patient’s world. It is advocated for use in practice and has been suggested as a valuable tool for medical revalidation (Mercer and Howie, 2006).

Communication

Good communication is the foundation of all relations, but is especially pertinent to those in healthcare (Zoppi et al., 2002) and plays an integral part in the healing process (Neuwirth, 1999). It is associated with a greater sense of choice, better outcome and higher satisfaction with care (Liang et al., 2002). Communication is particularly important in service for populations which hold different values, cultural beliefs and attitudes about health which can

affect illness outcomes and patient satisfaction (Fortin, 2002); the need to tailor communication and styles to these diverse populations is also an important consideration (Heisler et al., 2002; Davidson and Mills, 2005). The importance of non-verbal communication should also be recognised when considering the patient's encounter (Griffith et al., 2003). The ability to communicate and the results of communication training and its effect on satisfaction can be difficult to measure accurately (Meredith, 1993); this should not, however, preclude training for healthcare staff. Doctors who have undergone training were found to sound more interested (Roter et al., 1998) and nurses demonstrated greater job satisfaction (McGilton et al., 2006), but the training programmes must be suitably robust to produce results (Brown et al., 1999).

The elements of communication within the consultation have been extensively studied in medicine by Williams et al., 1998. The provisions of information (Stiles et al., 1979; Roter et al., 1988) and counselling (Shaw et al., 2005) have been cited to be significant, although this is disputed by Kim et al., (2004). Longer time spent with patients in discussing their condition was also highlighted as enhancing the perception of good communication (Freemon et al., 1971; Robbins, 1993); delivery style was also shown to be significant. Listening, empathising (Zachariae et al., 2003) and understanding of patients' or their relatives' concerns (Korsch et al., 1968) were regarded as empirical to patient satisfaction. Time spent on physical examination and case history-taking were regarded as less important (Freemon et al., 1971; Robbins, 1993). The method of gathering informed consent prior to examination and treatment has also been shown to be related to patient satisfaction (Agre et al., 1997; Pape, 1997). The ever present shadow of malpractice litigation has also been shown to be strongly linked to communication and patient satisfaction (Neuwirth, 1999).

Epstein et al., (2004) investigated intrinsic components of communication within a therapeutic setting. They noted that this involves not only the time spent with a healthcare professional, but also included discussions with family members after seeing a professional, and how easy it is to arrange an appointment.

Patients' expectations of shared decision-making are a growing feature, reflecting the more important role of the patient in healthcare communication. Kraetschmer et al., (2004) explored the relationship between the expectation for decision-making and the role of trust in the therapeutic relationship. This was measured by the Problem Solving Decision Making

Scale. Patients who had low levels of trust preferred autonomous roles in treatment decision-making. Patients who preferred a passive role had high - and sometimes "blind"- levels of trust. Luster's investigation of trust demonstrated that some patients extended their sense of trust, ceding a discretion to their healthcare professional to "do whatever is necessary" to put right whatever is wrong with them (Luster, 1994). Goodwill features in the conceptualisation of trust, particularly inter-personal trust. Trust incorporates a confidence in the goodwill of the person trusted towards the person who trusts (and may otherwise be vulnerable), emphasising the ethical dimension as well as the social and psychological dimension involved in a therapeutic relationship. The capacity to understand patients' individual experience, and building a partnership and sharing of power were cited as facilitating trust in a therapeutic relationship (Thom, 1997).

O'Connor et al., (1999) suggested that the use of decision-making aids would be helpful for patients. They could help to show the probabilities of symptom relief or life extension, thereby delivering more realistic expectations. Holmes-Rovner (2005) suggests that as patients' expectations become more realistic this could reduce the utilisation of healthcare and promote the use of more appropriate medical interventions and may also decrease litigation.

Williams et al., (1995) investigated communication and expectation using Levenstein's definition of expectation, i.e. "the individual's stated reason for the visit that often relates to a symptom or a concern, for which is anticipated an acknowledgement or response from the physician". The most frequently cited desire was an "explanation of the problem" this was followed by support, tests and diagnosis. Explanation of the problem produced a subtext about whether the patient felt the doctor had understood their problem. Hornbereger et al., (1997) and Jackson et al., (1999) identified that explicitly seeking information concerning their patients' expectations improved practitioner satisfaction with the encounter.

Cedrashi et al., (1996) examined the role of congruence between the perceptions of the therapist and the patient. This is a reflection of the relationship between therapist and patient which can be therapeutic or detrimental to effective treatment (Cherkin and MacCornack, 1988; Cherkin and MacCornack, 1989; Robert, 1989; Wright and Morgan, 1990). Overestimation of success by a therapist can account for non-congruence with a patient. Deyo and Diehl (1987) echoed these findings in their work; if patients are optimistic,

therapists are even more so. Congruent patients seem to accept living with their back problems, a view shared by their therapists. Non-congruent patients, on the other hand, despite similar experiences with sickness and treatment, did not share this conception of back pain. This means that patients can respond less favourably to treatment. It may be explained in part by the distance in educational terms between therapist and patient.

Expectations for information provision

Changes within the National Health Service agenda promoting the empowerment of patients has led to a demand for good quality evidence-based information developed with input from patients (NHS Executive, 1996; Department of Health, 1999). Unfortunately what has resulted in some cases is a large, and often unregulated, expansion in patient information through leaflets, web sites, books and other web-based technology. Research evidence suggests that patient information may have a place in addressing the role of the low back pain epidemic and can alter knowledge and behaviour, reduce referrals to secondary care and admissions to hospital, and has a positive outcome in low back pain patients (Roland and Dixon, 1989; Symonds et al., 1995; Evans et al., 1996; Burton et al., 1999). Some healthcare practitioners have concerns about patient information material; the Back Book (TSO, 2002) has been cited as attempting to "medicalise" low back pain, conferring a disease status to what is regarded by many practitioners as a benign symptom (McIntosh et al., 2003). Patients in the McIntosh study cited the conflicting nature of information which some patients felt undermined its validity. Equally some GPs felt that such material encouraged unrealistic expectations in patients. Patients may rate other sources of "evidence" including that of their friends and family (Entwistle and O'Donnell, 2001). The key to providing information that does not raise unrealistic expectations appears to hinge on the fact that evidence-based information should be promoted as carrying "optimum health advice". Equitable access for patients to advice that addresses the problem of diagnostic and treatment uncertainties and improved clinician communication skills may help to overcome unrealistic expectations (McIntosh et al., 2003; Shim et al., 2007).

Expectations of treatment

Very few studies have addressed explicitly expectations of treatment. It was investigated, in general, by Yardley et al., (2001). Emphasis was placed upon physical realignment of the

spine through a high velocity low amplitude (HVLA) thrust that was perceived to give instant relief from pain. A similar perception has been expressed of osteopathy; patients favoured the manual nature of manipulation and judged it an appropriate treatment due to its manual nature (Westmoreland et al., 2006). Further aspects of expectation of osteopathic treatment are covered in the section above on osteopathic care.

2.9 Expectation in different health conditions

Low back pain and expectation

Low back pain represents a considerable cost to the public purse. In the UK, direct costs have been estimated at £1,632 million in 1998, with indirect costs adding another £6,650 to £12,300 million (Mandiakis and Gray, 2000). This condition is extremely common; it has been estimated that 30-40% of the adult population will have one episode per year, and the life-time prevalence is over 60% (Croft et al., 1997). A successful outcome has financial as well as social implications for the individual patients concerned. A vast number of therapeutic interventions have been investigated in relation to patient expectation. They hold the common thread of the desire for a successful outcome. Graz et al., (2005) examined the expectations of patients undergoing surgery for low back pain and sciatica. Two different cohorts of patients were investigated, one whose pain was due to disc injury, and another whose symptoms were due to spinal stenosis. Graz et al., (2005) identified that the overly optimistic expectations of the surgeons were not matched by the judgement of a good outcome for the patient. A notable confusion was identified that psychological dimensions improved in patients who did not meet commonly accepted criteria for particular treatment interventions. It was proposed that this may have occurred because the healthcare practitioner involved invested more time and care in these particular patients who may have represented a therapeutic and intellectual challenge, a phenomenon termed the "curabo effect" (Clarkin et al., 1987; Priebe and Gruyters, 1995). The difference from the placebo effect, found to be high in back pain, is that this is based on the physicians' sense of expectancy of outcome instead of the patient's (Kalauokalani et al., 2001).

Expectations are learnt from experience of back pain; previously experiencing ineffective interventions may lead a patient to think that any new intervention being offered will be ineffective and undermine its potential outcome. These observations can be addressed to try

and enhance the efficacy of treatment. Carr et al., (2001) suggest that significant success can be achieved by changing negative expectations or creating positive expectations of health and health services (Freund et al., 1971; Thomas, 1987; Hashish et al., 1988; Rabkin et al., 1990; and Roberts et al., 1993).

Verbeek et al., (2004) undertook a systematic review looking at both qualitative and quantitative studies involving both expectation and satisfaction with low back pain management. Many of the studies identified supported the positive relationship between patient satisfaction and compliance with drug treatment (Arnsten et al., 1997; Williams et al., 1998; Murphy et al., 2000; O'Malley et al., 2002). The same has not been shown for back pain, with the exception of the work by Kalauokalani et al., (2001). Common themes emerged in all of the twenty studies reviewed. These included the expectation of a clear diagnosis of the cause of the pain, information and instructions, pain relief, and a physical examination. Minor expectations included referral for diagnostic tests, to other forms of therapy, or to specialists, sickness certification, and confirmation that the pain was real. Understanding, listening, respect and being included in decision-making were explicit themes in qualitative studies and were confirmed by quantitative studies. Confirmation that the pain is real was emphasised in the findings of Glenton (2003) who interviewed patients who felt they were unable to achieve the sickness role due to lack of clear diagnosis and were subsequently labelled as malingering, hypochondriacs or suffering from mental illness. The lack of ability to provide a clear diagnosis, explanation or form of treatment increased the patients' dependence on their healthcare provider. This also meant that the symptoms failed to become socially meaningful (Frankenburg, 1980). Dumit (1988) noted that patients in this context inhabit a luminal space where they are both sick and well, but not definitely either of these. This can render patients feeling discreditable or discredited which over time challenges their identity (Kleinman et al., 1995). Access to healthcare, whether privately or publicly funded can be viewed as proof of suffering (Glenton, 2003). This concept is challenged for back pain sufferers particularly who fear being stigmatised by their back pain (Borkan et al., 1995; Rhodes et al., 1999; Walker et al., 1999); to some it has been viewed as a character blemish (Goffman, 1968). Glenton (2003) identified that a clear expectation for patients, particularly those with low back pain, was for a firm diagnosis and confirmation that the pain was real. Frankenburg (1980) highlighted the fact that for some patients back pain symptoms can be viewed as "socially meaningful". This can be related to the fact that patients may

have no outward symptoms but nonetheless be in considerable distress which is hard to express to work colleagues or peers.

May (2007) examined the impact of patients' attitudes and beliefs on the management of back pain. This builds on the work of Verbeek et al., (2004) who looked at expectations of management of low back pain. May identified that for most patients, their expectation of manual treatment of low back pain was that it would involve exercises, whereas more patients preferred to be involved in the management of their symptoms, and were not expecting a complete cure. Previous work by Cedraschi et al., (1996) identified that patients had mixed expectations concerning their prognosis ranging from full recovery to a gradual worsening of the condition. The work by McCracken (1998) more closely mirrored the findings by May that more patients accepted recurrences of symptoms and expected to make adjustments to maintain functional independence.

Toyone et al., (2005) identified that some expectations of care were unfulfilled due to the over emphasis on pain. Patients undergoing lumbar spine surgery were found to expect improvement in post-operative functional status to the same extent as pain relief. Expectations have been used by some clinicians to act as predictors of outcome in patients with low back pain (Myers et al., 2007). They found that patients with higher expectations of recovery with acute low back pain also experienced greater functional improvement. This has been mirrored in studies addressing joint arthroplasty and in connection with specific therapies (Kalauokalani et al., 2001; Mahomed et al., 2002). The effect of expectations on long term outcome has also supported this finding (Skargren and Öberg, 1998).

Linde et al., (2006) further explored the role of expectations with acupuncture in chronic pain patients. They looked at the data from four separate clinical trials and found that high personal expectations of treatment were consistently associated with significantly better outcomes.

Heymans et al., (2006) examined the effect of expectations on the ability to return to work after 12 months. The timing of lasting return to work and first return to work was 76 and 71 days respectively. The most effective strategies focussed on developing interventions which focussed on patients' expectations about the success of the treatment and the abilities of the occupational physicians who are managing their care. The ability to communicate effectively about evidence based interventions related to pain management, pain intensity and pain

radiation was also cited as relevant to return to work (Hagen et al., 2000; Epstein et al., 2004). McCarthy and Oldham (2005) also identified information concerning prognosis.

Grimmer et al., (1999) investigated how expectations vary between different stakeholders in healthcare. They surveyed the views of patients, referrers, physiotherapists, and third party payers e.g. insurers. Patients were specifically asked about their rationale for returning for a second appointment. Referrers cited good short-term relief, long-term education and taught self-management. Insurers and third party funders cited their main expectation as not incurring large expense; minor expectations also included time spent with the patient, and the treatment provided. Physiotherapists cited their expectations as returning patients to their pre-injury state, and implementation of long-term management strategies. Patient responses included the expectations that treatment would be provided in a convenient location, by a therapist with a good reputation, and previous good experience and/or recommendation. Physiotherapists were asked about areas where they felt dissonance between their expectations and that of patients would arise. They cited patients' unrealistic expectations of a complete cure, expecting to attend for treatment only once, and the failure of patients to commit the time, effort and responsibility to maintain their improvement. No significant differences were identified between patients or physiotherapists in a rural or urban setting or between private practice or hospital settings. The study did, however, identify some differences in expectations between experienced and naïve patients. Experienced patients expected information about their treatment, diagnosis, treatment process, long-term management and outcome.

Chronic conditions

Few investigations have taken place looking into patients' expectations of treatment for pain. Turner et al., (2002) examined expectations of pain relief in chronic pain associated with spinal cord injury. Patients were found to have lower expectations of relief than attending healthcare professionals, and were better able to anticipate their levels of post-treatment pain relief. The primary focus for many pain studies has been with patients experiencing chronic pain; such patients frequently present with multiple presenting problems, including functional ability, and it is important for any pain questionnaire to focus on the many domains of concern for the patient (Robinson et al., 2005). The additional domains considered by

Robinson et al., (2005) included pain fatigue, emotional distress and interference with daily living; they were assessed using the Patient Centred Outcomes Questionnaire (PCOQ).

Compliance with treatment regimes, involvement in self-management, failure of healthcare resources and access, strategies to change behaviour and its effect on outcomes were explored by Jerant et al., (2005). Medical students were asked to identify all of the demands on patients with long term illness and chronic conditions. This showed there had been a failure on the part of the clinicians to appreciate all of the demands placed on patients. Their expectations of patients, and understanding for lack of compliance with certain aspects of their treatment management and care were re-evaluated in view of the study. The failure of health professionals to appreciate the barriers that patients encounter in engaging in self management strategies, can affect a therapeutic relationship and promote confused expectations.

2.10 Outcomes of care and expectation

Patient satisfaction

The relationship between satisfaction and expectation has been extensively studied (Brody and Miller, 1989; Fitzpatrick, 1991; Carr-Hill, 1992). In multidisciplinary settings within the NHS, the expectations of patients receiving acupuncture, osteopathy and homeopathy have been studied, and seven distinct themes were identified; the outcome of symptomatic relief was the primary expectation (Ong, 2003; Sigrell, 2002; Richardson, 2004; Linde., 2007), although CAM patients didn't necessarily expect a "cure" (Sigrell, 2001). The other themes were the therapeutic or holistic approach, an improved quality of life, provision of information, reducing the risk of allopathic medical treatments, the need for advice regarding self-help, and accessibility of CAM treatment(s) in the NHS. Further studies have supported these findings, focussing on an holistic approach, and assessment of the whole person (Thompson et al., 2007; Paterson, 2008). The desire to control and self-manage health with the support of CAM has also been cited (Ong, 2003). Others have found improved quality of life, and reduction of medication and their side effects are reported as important expectations (Thompson et al., 2007; Eustachi et al., 2009).

The views of patients and satisfaction with care in a general practice setting were investigated by Pincus et al., (2000). A number of aspects of care appeared to contribute to satisfaction.

Three subscales were measured following modification of a measurement tool for chronically ill patients (Fitzpatrick, 1991). The subscales included competence (including training, diagnosis, thoroughness in examination and tests, and planning treatment), quality of care (including personal relationship, listening and caring) and efficacy (including improvement in health and reduction of symptoms).

Patient expectations are of clinical importance, for example, positive expectations of recovery have been found to be associated with greater functional improvement from treatment (Myers et al., 2007). A study of patients receiving acupuncture or massage for low back pain found that those with positive expectations were five times more likely to have a substantial improvement, compared to those with lower expectations. The link between positive expectations and improvement was found to be treatment specific (Kalauokalani et al., 2001). Conversely, unreasonable expectations have been identified as detrimental to the therapeutic relationship and indicative of 'the difficult patient' (Potter, 2003).

Osteopathy as a system of healing will encompass different expectations in its approach to managing patients. This has been acutely evident in the issue of "adverse events". The occurrence of soreness or a provocation of symptoms in the first 24-48 hours after treatment is regarded by many osteopaths as normal. This has been displayed in the work by Carnes et al., (2009) while attempting to define adverse events. This study builds on the work by Cagnie et al., (2004) who attempted to identify what are common and short-term effects of "manual therapy". The traditional views enmeshed in naturopathy find the notion of a "healing crisis" quite acceptable in the management of a patient's symptoms (Lindlahr, 1926): similar views are expressed by osteopaths in Carnes' work (2010).

Expectation and quality of life

Carr et al., (2001) suggest that everyday life is composed of a complex series of events which require answers. The answers are provided by simplifying thoughts using a stable set of assumptions, or expectations, to inform our observations. In an acute episode of back pain, for example, this will provide answers concerning the treatment, the amount of pain that will be experienced, and how effective the treatment will be. Measures of quality of life summarise the judgements patients make concerning previous experiences of health and illness, and the impact new illness will have on the ability a person will have to return to their

previous levels of function. The relation between symptoms and quality of life is neither simple nor direct. Consideration of the discrepancy between expectations and experience provides an explanation of how to evaluate it (Calman, 1984).

Carr et al., (2001) suggested a model representing three very real difficulties in measuring patient expectation:

- People have different expectations – expectations are learnt from experience and may be highly specific; they vary between individuals and are subject to different social, psychological, socioeconomic, demographic and other cultural factors. Expectations about quality of life are closely allied to their environment and their ability to adapt to changing circumstances can dictate successful coping strategies in life. This has been cited in elderly populations (MacEntee et al., 1997)
- People may be at different time points in their illness trajectory
- The reference value of a patient's expectation may change over time. Quality of life is a dynamic construct; the mechanisms by which individuals evaluate their life change constantly over time and in response to many factors in their life (Deiner, 1984; Headey et al., 1984; Bunk et al., 1990; Chamberlain and Zika, 1992; Englert et al., 1994; Allison et al., 1997). This problem of "response shift" is compounded if repeated measures are made, for example when evaluating an intervention (Addington-Hall and Kalra, 2001)

Calman (1984) proposed that quality of life represented the gap between expectation and the reality of the situation. A narrowing of this gap, either by lowering expectation or improving experience could enhance the quality of life. The highly individual nature of quality of life and the influence of culture and previous experience is acknowledged, but critics argue that Calman's assertion means that individuals from lower socioeconomic backgrounds with lower expectations have a better quality of life than those with higher expectations but the same experience.

Koller (2000) has examined the variables associated with expectation in cancer patients. The expectation of healing, and preventing tumour relapse were cited. Expectations were driven by communication and the information given, and this was often a cause for complaint. Healing expectation was also found to be strongly correlated with quality of life prior to treatment.

Effectiveness of care

Verbeek et al., (2004) undertook a systematic review of patient expectations of treatment for back pain which encompassed both allopathic medicine and CAM approaches including manual therapy. They concluded that pain relief is the primary driving force in seeking treatment, and within clinical management, patients' primary expectation was to learn the cause of their pain and to receive information and advice concerning its management.

So (2002) investigated the effect of expectation on treatment outcomes for acupuncture. He found that patients with very high expectations of acupuncture were more likely to encounter a poor outcome compared with patients who had a lower expectation.

Expectations of outcome of musculo-skeletal problems

Berry et al., (1980) examined the explicit expectations of patients when they were tailored to appropriate treatments. Patients with specific expectations of relief e.g. in terms of mobility were found to benefit from targeted pharmacological treatments. The study demonstrates the importance of identifying the specific expectation of patients with multi-sensory symptoms and not just assuming that pain relief predominates.

Kapoor et al., (2006) investigated the differences between patient and clinician expectations of return to work. Low back pain is a common disorder, affecting around one-third of the UK adult population each year. Estimates for the adult population burden of chronic back pain include; 11% for disabling back pain in the previous three months, 23% for low back pain lasting more than three months and 18% for at least moderately troublesome pain in the previous month (Andersson et al., 1993; Cassidy et al., 1998; Parsons et al., 2007). One year after a first episode of back pain 62% of people still have pain and 16% of those initially unable to work are not working after one year (Hestbaek et al., 2003). Typically, pain and disability improve rapidly during the first month; (58% reduction from initial scores for both pain and disability) with little further improvement being observed after three months (Pengel et al., 2003). Treating all types of back pain costs the NHS more than £1,000 million per year. In 1998, the direct healthcare costs of all back pain in the UK were estimated at £1,623 million – approximately 35% of these costs were related to services provided by the private sector. It is estimated that the costs of care for low back pain exceed £500 million per year in

the private sector, with the NHS incurring costs of over £1,000 million. Lost production as a result of low back pain costs at least £3,500 million per year (Mandiakis and Gray, 2000).

Kapoor et al., (2006) compared patient and clinician expectations of the possibility of returning to work after an episode of low back pain. Patient expectations were associated with differences in pain, mood, prior back pain, job demands, functional limitation, and marital status. The association between psychological factors and risk factors for disability have been well documented (Shaw et al., 2001; Linton et al., 2005; Steenstra et al., 2005). Patients who had negative expectations of return to work before seeing a clinician were found to be less likely to have returned to work within 1-3 months, and were at greater risk of chronic pain and disability. Patients were found to form expectations very early after their onset of pain which were detrimental to their chances of return to work. Clinicians' expectations, in contrast, focussed on physical examination findings. Workplace physical demands, the feasibility of receiving modified working, and the confidence to self-manage pain all affected expectations of treatment outcome in relation to return to work (Dasinger et al., 2001; Shaw et al., 2005). Other studies investigating sub-acute and chronic low back pain show that patient expectations are an independent predictor of prolonged disability (Cole et al., 2002; Schultz et al., 2002; Shaw, Pransky et al., 2002; Dionne et al., 2005; Gross et al., 2005; Boersma et al., 2006).

Iles et al., (2009) reviewed a number of time-based, specific single item tools to predict the effect of expectations on the ability to work. He found that a number of tools exist which can identify people with non-specific low back pain who are at risk of poor outcome. The single statements most commonly assessed included disappearance of pain, risk of developing chronic low back pain, ability to work unrestricted , and return to work (Dionne et al., 2005; Hagen et al., 2005; Jellema et al., 2006; Kapoor et al., 2006). Kuijer et al., (2006) also undertook a systematic review to examine prediction of sickness absence in patients with chronic low back pain. They found that no core set of predictors exist for sickness absence in general, but higher expectations of recovery correlated with a reduced sickness absence and early return to work. Lawrie (1976) echoed these findings when she stated that healthcare professionals have very different attitudes to healthcare and feels they impact on patients' expectations, but not necessarily satisfaction. She cited that although staff may have competing needs and demands on their time, this is often appreciated by patients who feel that it doesn't affect their access to treatment and care.

2.11 The physiological effects of expectation

A growing body of literature has looked at the neuroscience behind expectations and the effect when expectations are challenged. Early studies have investigated the effect of the expectation of being able to fulfil a number of specific tasks, or situations where expectations occur in particular settings. The neuro-scientific approach has attempted to investigate brain activation in tasks where expectations are challenged.

Bubic et al., (2009) investigated how patterns of task activity affected brain behaviour and detected a mismatch between the expected and presented; this updating process of the underlying sequence representation was described as the forward model. The detection of changes in expectations was found to produce an increase in activity in pre-motor and cerebellar components in the sequencing network and activations of the frontal areas not normally involved in sequencing. This work supports the earlier findings of de Hempetinne et al., (2008).

The phenomenon of expectation and reward has been well researched, leading to the theories of Pavlov. Expectancy states have been shown to enable successful adaptations to environmental demands (Delameter, 2007). Further work has been undertaken by Savage and Ramos (2009) who studied the effect of expectancy on cognitive strategies and the amygdala. The results of their studies indicate that expectancy can change both behavioural and brain processes.

The differences in brain responses to the expectation of painful stimuli have been studied by Labus et al., (2007). This work focussed on sex differences when pain was expected in patients presenting for investigations into irritable bowel syndrome (IBS). The results of this pilot study indicated that when brain network analysis was studied, three separate networks were involved which corresponded to visceral afferent information processing (involving the thalamus, insula and dorsal anterior cingulated cortex, and orbital frontal cortex); emotional arousal (involving the amygdala, rostral and sub-genual cingulated regions, and locus coerulus complex); and cortical modulation (involving the frontal and parietal cortices). The researchers proposed that sex differences in the cortico-limbic circuitry involved in emotional arousal, pain facilitation and autonomic responses may underlie the observed differences recorded.

2.12 Unmet expectations

Unmet expectations represent the gap between a patient's expectations of care and the care that they perceive they receive. Kravitz et al., (1996) sought to identify influences on the development of patients' expectations by interviewing patients whose expectations were unmet. Based on telephone interviews with 125 patients from three general internal medicine practices they identified four major sources of unmet expectations: somatic symptoms (74%), perceived vulnerability to illness (50%), previous experience (42%), and transmitted knowledge (54%). Patients felt the severity of symptoms and extent of their distress was under-appreciated, or the physician failed to recognise their need for reassurance about the possibility of serious disease. Perceived vulnerability related to aging, pre-existing conditions or family history of illness. Personal lifestyle factors were sources of heightened concern for patients that they felt were insufficiently acknowledged and acted upon during the consultation. Patients often do not voice such concerns unless asked about them; physicians may find themselves arguing with patients about a particular clinical strategy (Kravitz et al., 1996). Unmet expectations were also shaped by past experiences of similar symptoms or experience of caring for others. Patients described expectations acquired through personal education, conversations with friends, relatives and other health care professionals or the media. More medically sophisticated patients reacted harshly to perceived omissions, and when the advice of trusted others was challenged patients became suspicious.

An effect of unmet expectations on the practitioner-patient relationship was described by Jackson and Kroenke (2001) who found that they were common among patients labeled as 'difficult' by clinicians. The authors concluded that diagnostic and prognostic information are valued by patients and implied that patient education may help to decrease difficult behavior. Similarly, in a study of 'the difficult patient' in private physiotherapy practice, Potter et al., (2003) identified two problems relating to patient expectations. The first involved patients with unrealistic expectations, "Patients who want a quick fix in one session when that is not possible". The second problem reflected patients with preconceived ideas about physiotherapy, "Patients who have preconceived ideas about the number of treatments they require and the treatment methods that should be used are always hard to manage". Providing unnecessary and inappropriate therapeutic and diagnostic interventions, for the

sake of attempting to meet perceived expectations to maintain a relationship with a patient, is inadvisable and ultimately leads to poorer outcomes for the patient (Belle-Brown, 2003; Little, 2004). Equally, expectations can change during the course of treatment and failure to identify and respond to such changes can adversely affect satisfaction even though the treatment delivered remains constant (Goldstein, 2000).

Jackson et al., (2001) also looked at how expectation and satisfaction can change at different time points. In contrast to earlier studies, they found that at all time points, the presence of unmet expectations decreased patient satisfaction. Variables that increased satisfaction post-visit included receiving an explanation of the likely cause of symptoms as well as the expected duration of the symptoms. At 2 weeks and 3 months post treatment, experiencing symptomatic improvement and improved function increased satisfaction, while additional visits (actual or anticipated) decreased satisfaction.

Hooper et al., (2005) identified that lack of agreement concerning the need for clinical tests was the greatest source of unmet expectations between physician and patient; good concordance was found at other times. Edwards (2008) investigated what happens when patient expectations are not met and the unexpected reaction to this is simply not foreseen. In some professional areas this can result in the completion of a significant event audit form to examine clearly what has happened, how things could be different and what can be learned from the experience.

The emphasis that some patients place on certain elements within a consultation can create a dissonance that may be unrecognised by the practitioner, but nonetheless results in expectations failing to be met (Atiba, 1993; Peck, 2004; Esposito, 2005). Sigrell (2001) demonstrated that dissonance existed in terms of the elements of the chiropractic consultation which were viewed as more important by patients and chiropractors.

Consistent with previous research, unmet expectations were seen more frequently in younger patients (who may harbour more expectations), unmarried patients (who may lack an accompanying medical advocate), and patients who lack trust in medical professionals (Kravitz et al., 1996; Bell et al., 2002). In the work by Bell et al. (2002) unmet expectations concerning data collection, including case history-taking, were cited. Case history-taking has been shown to affect satisfaction as it has been cited as a prerequisite for a comprehensive understanding of the patient's situation (Sherbourne et al., 1992; DiMatteo et al., 1993). This

challenges the findings of Freemon et al., 1971, and Robbins, 1993. Active listening alone - without case-notes and without treatment- was positively associated with feeling worse. Clear explanation and a favourable prognosis have been linked to feeling better (Fassaert et al., 2008). The process of actively raising positive expectations has been suggested by Fassaert et al., (2008).

2.13 Measuring patient expectations

A variety of different methodological approaches have been adopted to measure patients' expectations. Several different instruments can be utilised also. These can may indicate quality of care (Cleary and McNeil, 1988; Rubin et al., 1993, Laine and Davidoff, 1996; and Rosenthal et al., 1997) but can also influence the utilisation of healthcare (Eisenthal et al., 1985; Ulhmann et al., 1988) and affect patient satisfaction (Eisenthal et al., 1985; Like and Zyzanski, 1987; Brody et al., 1989; Joos et al., 1993; and Kravitz et al., 1994).

Clinicians, policy makers, and researchers place great importance on patients' expectations but no standardised instrument to measure this variable currently exists. Instruments in common use have been constructed in a variety of ways: some employ open-ended questions, while others use a list of expectations both real and desired. The language used in the current array of questionnaires varies considerably and is open to interpretation. Kravitz (2003) cites the "value" approach focussing on and interpreting patients' desires. Words such as "want" or "would like" are employed (Joos et al., 1993; Zemencuk et al., 1998); other questionnaires ask what patients think "is necessary" (Brody et al., 1989; Kravitz et al., 1994). Expectations can also be interpreted to mean outcomes when patients are asked about what they "think is likely to occur" (Kravitz, 1996; Peck et al., 2001). Different tools can raise expectations, or heighten awareness of unmet expectations by focussing on areas which patients may not have previously considered. Peck et al., (2001) investigated how the instrument itself can affect expectation and utilised three commonly used instruments to measure different aspects of expectation in patients and their sensitivity in measuring true patient expectations. Two assessment instruments were used, differing in both structure (a list of potential expectations from which to choose) and wording of the questions ("want" or "necessary"). Three particular categories were investigated which are common and costly: diagnostic tests, referral to a specialist, and new drug prescriptions (Marton et al., 1980; Woo et al., 1985;

Woolf and Kamerow, 1990; Joos et al., 1993; and Kravitz et al., 1994). An abbreviated version of the Patient Request for Services Schedule (Like and Zyzanski, 1987; Like and Zyzanski, 1996) was used; a longer instrument included additional questions about specific expectations nested within questions about referrals, tests and new medications. Analysis of the results showed that the longer instrument resulted in patients identifying an average of two expectations focussing mainly on tests; patients completing the short instrument identified an average of one expectation. Satisfaction did not differ between the patients using the two instruments, although the number of unmet expectations was higher in the group using the long instrument where more choices were evident. Earlier research by Kravitz et al., (1997) observed that more expectations were identified from a structured questionnaire than by interview. However, a lack of association was also found between the type of instrument and expectations; this finding supports the work of Kravitz et al., (1994) who also found that satisfaction did not differ whether questionnaire or semi-structured interviews were used. Peck et al., (2001) found no association between unmet expectations and satisfaction; they cited a number of possible explanations for this. Firstly, patients may be satisfied that they have been asked about their satisfaction and expectations, and these have been recognised as being important; secondly existing measures may not be sensitive enough to measure patient satisfaction. Thirdly, fulfilled expectations of the criteria the researchers used (tests, referrals, and medication) may be too narrow to be a significant determinant of patient satisfaction.

Delgado et al., (2008) investigated the effect of different clinical scenarios on patient expectations. They considered that previous authors had investigated expectation in terms of "preferences" (Little et al., 2001), "priorities and normative expectations" (Wensing et al., 1998), "priorities" as an attribute of importance (Grol et al., 1999), and "intentions" (Salmon et al., 1994). Delgado et al., (2008) used a thirteen point scale and assessed expectation in patients with a range of specific health conditions: strong chest pain (severe acute problem suggestive of myocardial infarction), genital discharge (genitourinary problem affecting either men or women), the common cold (mild acute problem), depression/sadness (psychological problem), and a serious family problem affecting health (family problem). This supported the assertion of Staniszewska and Ahmed (1999), who identified in their work on nursing that due to the complexity and instability of patient expectations, they should be measured in homogenous populations with specific diseases. Delgado et al., (2008) found

that the main expectation for patients was to be listened to in all cases except patients with a cold. The second most common expectation was for interest to be shown and this was true for all conditions. In 50% or more cases the patients stated that they wanted the practitioner alone to make decisions, although patients wanted their opinions to be considered. Consultation duration was the most important expectation for psychosocial conditions, but less so for physical conditions where test and referrals were expected. This supports the findings of earlier work by Grol et al., (1999).

A number of other questionnaires in this area were assessed. Issues concerning treatment beliefs, locus of control and individual disease groups were examined. Bishop et al., (2007) undertook a systematic review of beliefs involved specifically in patients using alternative and complementary medicine. This work was informed by earlier work in the development of a measure of treatment beliefs which formed an inventory within CAM interventions (Bishop et al., 2005; Bishop et al., 2008).

A considerable body of work examining expectations has focussed on specific conditions including upper respiratory tract symptoms (Brody et al., 1986; Olsson et al., 1989; Sanchez-Menegay et al., 1992; Hamm et al., 1996; Macfarlane et al., 1997); diabetes mellitus (Uhlmann et al., 1988); or physical symptoms (Deyo et al., 1986; Deyo et al., 1987; Brody et al., 1989; Froehlich et al., 1996; Marple et al., 1997; and Jackson et al., 1999). The focus of these studies has been medication prescription or diagnostic testing but the survey instruments employed used fewer questions than those in the studies eliciting general expectations from patients. In many studies, looking at general expectations, information and reassurance were sufficient to meet patients' expectations.

2.14 Discussion of the literature review

This review of the literature on expectations from a range of different healthcare contexts has provided a comprehensive overview of the evidence that exists about patient expectations, the factors that influence them, and how expectations may influence or be influenced by care and outcomes.

The literature review was drawn from a total of 1108 papers, the majority published since 1970, within which there were 135 key papers: 18 focussing on expectation in complementary therapies, 11 within manual therapies, 10 within osteopathy; there were 89

reporting on features of expectation and 7 related to patient satisfaction. Literature focussed on:

- Definitions of expectation;
- Theoretical models of expectation;
- Factors influencing expectation;
- Patients' expectations of all healthcare practitioners;
- Expectations of the consultation;
- Expectations of osteopathy (preliminary evidence);
- The relationship between expectation and satisfaction.

The full findings of the literature review represent a unique overview of patient expectations within healthcare and will be published as a scientific paper in the near future. For the purposes of this study, the literature was used to identify the factors that influence expectation; and the many factors influencing expectation were used to inform the focus group interviews and the questions to be asked in the survey.

Contextual and theoretical evidence on expectation

Definitions of expectations describe it as intrinsically linked with satisfaction and as an integral part of the psychosocial makeup of the individual, based within a variety of contextual frameworks. The contextual frameworks of patients relate to a number of different factors including their psychological makeup, their belief systems, the sense of vulnerability experienced, their interpretation of symptoms, their pre-formed ideas (both idealised or based on prior experience) concerning what will happen during and following a therapeutic consultation, and beliefs transferred from the experiences of others.

A theoretical understanding of expectation in healthcare includes aspects such as psychological factors, beliefs, service organisation, and the level of patient involvement in the therapeutic process. Five styles of practitioner were identified, with patient involvement described as one of: exclusion, paternalism, shared decision-making, practitioner as an agent, or informed decision-making. Concordance between patient expectation and practitioner style will influence the patients' expectations.

Theoretical models of expectation refer to the "gap" between patients' expectations of a service and the service they perceive to be given. The unmet expectations in this gap have been shown to influence outcomes directly.

These theoretical perspectives were general, applicable to any type of healthcare including osteopathy at least within the Western world. The models describe how patients perceive healthcare, and how expectations are developed. They were therefore relevant to this study.

Current evidence on patients' expectations of healthcare

Published studies have identified patient characteristics that influence their expectations, including ethnic and cultural factors, age, the vulnerability of the patient, and the health problem(s) that they have.

The relevant healthcare factors, relating to the way the service is organised, include the presence of third parties, the healthcare setting, ease of access to treatment, and advertising. Within the setting, there are factors such as waiting times for appointments, ease of access, efficiency of referral, and chaperones.

The therapeutic encounter includes the quality of the interaction with the practitioner (personal factors such as trust, communication, congruence of understanding, confidence) and the technical quality of the consultation. Expectations of healthcare practitioners include the ability to communicate effectively, to behave in a professional manner while providing an organised and effective service, being professionally attentive to a patient's fundamental concerns, to provide an efficient triage process to find the problem, the ability to identify the cause of symptoms, to explain in an effective and understandable manner what is wrong, and administer appropriate treatment.

Key expectations of the consultation include a thorough case-history taking process while allowing the patient to "tell their story", a thorough assessment and provision of diagnostic information underpinning treatment. In the absence of diagnostic certainty, patients expect to be referred for appropriate tests. Information giving to both the patient and their relatives/carers, in combination with prognostic information were also highly sought.

Continuity of care and a mutually respectful and trusting relationship involving shared decision-making were also key expectations.

The relationship between satisfaction and expectation has been extensively studied and it can influence the outcome of care. Overestimation of success of the effects of treatment on the part of the therapist can contribute to reduced satisfaction. A variety of desirable outcomes have been described including symptom relief but not necessarily a cure, improved quality of life, the provision of information, the ability to reduce the use of medication, and being able to maintain functional independence.

The many factors identified in the literature as playing a role in patients' expectations of healthcare are summarised in Figure 2.5. These were based on studies primarily in primary or secondary orthodox medical care. For most factors, there was no specific evidence that they were important in osteopathy. In the next section, those factors specifically identified in osteopathic studies are presented.

Expectations of private osteopathic care (preliminary evidence)

The specific factors that influence expectation appear to vary according to the type of healthcare, and the evidence from osteopathy is extremely limited: there were 3 published studies and 2 undergraduate research studies within osteopathy, all within private practices, and some more general CAM studies that included osteopathy. These studies provided some preliminary evidence as follows.

The distinctive characteristics of osteopathic patients were:

- Having musculoskeletal problems, often chronic;
- Less worried about side effects of allopathic medicines than the generality of CAM patients;
- Private patients will bench-mark the quality of the service against NHS and other services;

The patients' expectations of the osteopathic service were related to five topic areas:

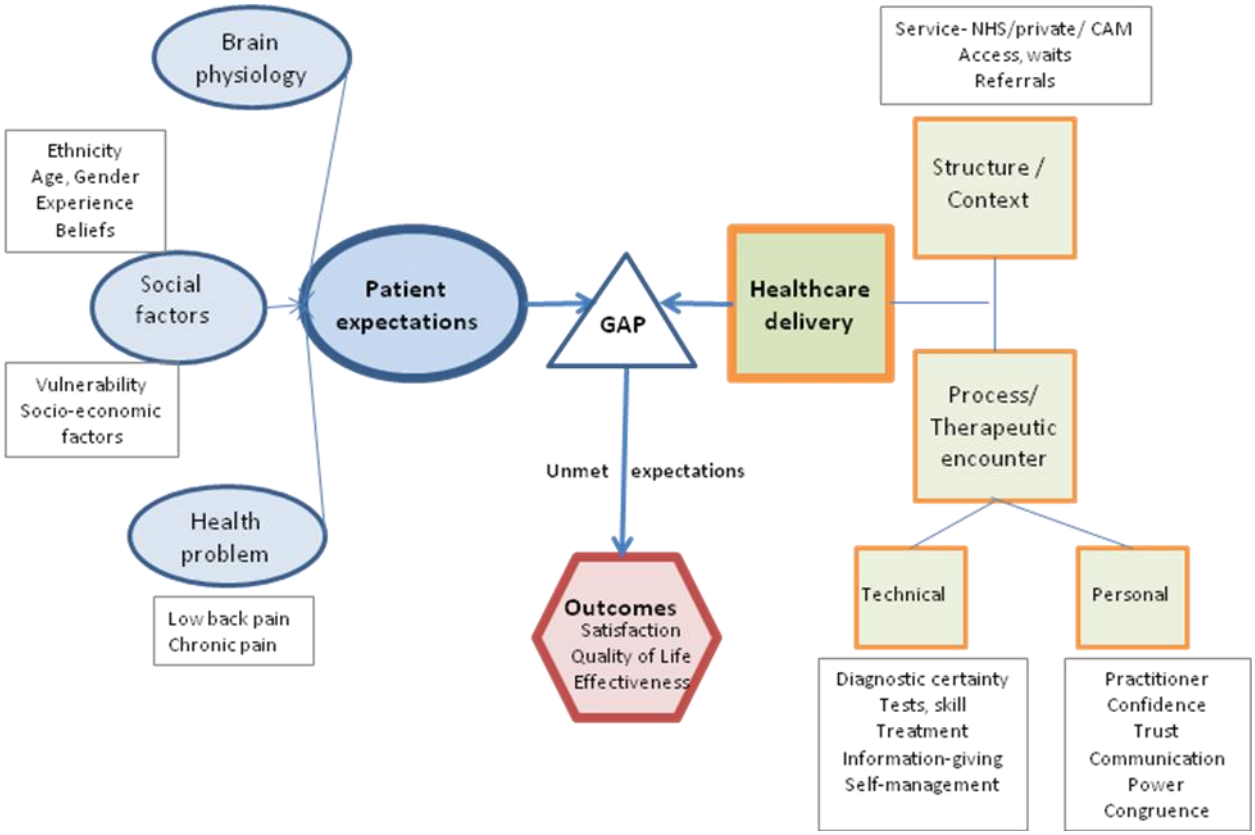
- Clinic Environment (healing, accessible, flexibility of appointments);
- Professionalism (continuity of care, technical skill);

- Treatment (effective manual treatment, physical realignment of the spine, advice and prescription of exercise, an holistic approach);
- Relationships (inter-personal skills; offers hope, communication, respect and trust; shared decision- making tailored to the individual);
- Outcome (reduction of pain, improved quality of life).

Two possibly unmet expectations were identified: forewarning patients about the need to undress, and evidence of discordance between patients and practitioners (chiropractic) in relation to expected improvement in symptoms.

All this evidence was preliminary, being based on small studies and requires testing in further research. The above factors can be considered as probably relevant to osteopathic patients, whereas we have no evidence at all on the relevance to osteopathy of all the other factors that were identified within the literature review. This was gained within the subsequent phases of the study. All the identified factors as represented in Figure 2.5 became candidate topics for use in the focus groups, and contributed to the development of the questionnaire for Phase 3 of the current study.

Figure 2.5 The factors that shape patients' expectations of healthcare



Main findings about measurement of expectations

A wide range of questionnaire instruments have been utilised to measure expectation and associated concepts such as attitudes and beliefs, using a variety of terms applied in various healthcare contexts. No standardised instrument to measure expectation currently exists. Instruments in common use have been constructed in a variety of ways: some employ open-ended questions, while others use a list of expectations, both real and desired. The language used in the current array of questionnaires varies considerably and is open to interpretation. None have been developed for use within osteopathy specifically to date.

Limitations of the literature

The quality of the literature was mixed. Higher quality evidence, involving both primary and secondary research, comprised 17 systematic reviews, and 31 studies using qualitative approaches, and the remainder was composed of clinical trials, surveys, opinion pieces and personal opinion. Some unpublished osteopathic literature from both BSc and MSc dissertations which were specifically osteopathic in focus were also examined.

Because of the subjective nature of expectations, understanding of the topic does not lend itself to clinical trials (i.e. high quality evidence) and many of the studies reviewed are exploratory and descriptive in nature; although measurement of expectation can be reliable when suitable, validated instruments exist.

Little work has been undertaken studying the contrasting expectations of patients being treated in NHS and privately funded sites. This factor was recognised in the planning of the UK BEAM trial (BEAM trial team, 2004), when interventions were provided in both NHS and private osteopathic settings to reduce environment as a confounding factor. The majority of studies in this area focus on patients who have seen CAM therapists, viewed as a homogenous group, predominantly within GP settings but with small comparisons with private care (Pringle and Tyreman, 1993; Paterson, 2008).

In a similar vein, little work has been conducted comparing differing expectations of care when provided in primary and secondary care environments. In addition, although there are many studies on expectations of the therapeutic encounter, there is surprisingly little evidence about expectations of the treatment itself.

Implications for osteopathy

The development of osteopathy into a profession regulated by statute (The Osteopaths Act, 1993) indicates a growing maturity. The incorporation of aspects of osteopathic care, notably spinal manipulation, into national and international clinical guidelines will inevitably increase expectations of the profession among patients and among other healthcare professionals (NICE, 2009; European acute and chronic low back pain guidelines, 2004). In contrast to many other health professions in the NHS, osteopathy has a distinctive holistic view of health which focuses on the patient as well as the presenting symptoms, which may assist in delivering patient-centred care.

Patients commonly present to osteopaths with musculoskeletal symptoms (Pringle and Tyreman, 1993; GOsC Snapshot Survey, 2001). Examination of the literature suggests that many factors need to be taken into account by the practitioner, in addition to the presenting symptoms, in order to understand the wide range of features that the patient might expect within the care provided: some explicit, others less visible.

It may not always be possible to provide the diagnostic certainty that the literature suggests patients expect (Verheek et al., 2004), or immediate symptomatic relief, particularly in patients with chronic pain states (Kalauokalani et al., 2001).

Expectation of outcome can be particularly problematic, particularly when relating to costly problems such as low back pain. Mandiakis and Gray (2000) identified that the total cost relating to low back pain, when combining both direct and indirect costs, for the UK in 1998 reached £12300 million. Chronic pain states place a burden on the public purse and a significant burden on sufferers and their dependants and carers. Many patients of this nature present in osteopathic practice and their prior use of healthcare services and the interventions provided can influence expectations of care.

Furnham (1995) found that patients attending CAM practices particularly expected that the general style of consultation and sensitivity of the therapists was especially important. This was particularly pertinent when patients experienced chronic pain. It is not unusual for patients with chronic pain states to present in practices where a range of CAM treatments are delivered and such patients have often experienced a long and unsuccessful journey through primary and secondary care (Pringle and Tyreman, 1993; Pincus et al., 2000).

It is understandable why patients feel that sensitivity and a caring approach by healthcare professionals are important. Watt (2005) made the assertion that patients attending for care are often frightened, in pain and anxious. Redman (2007) concurred with this view, stating that patients become vulnerable by the very fact that they have entered the healthcare system. Vincent (1996) identified that patients attending CAM practices represent quite a heterogeneous group and this makes it surprising that CAM patients are often highly satisfied with their care when there is so much potential for unmet expectations and lack of congruence in the approach to care. Congruence has been cited by many authors as being important in meeting expectations (Cherkin and MacCormack, 1989; Cedraski et al., 1996). This may well be true also within osteopathy; the evidence gathered within this project should provide some indication of whether this is the case.

There will inevitably be some tension between trying to meet the competing expectations of a more informed and demanding patient population and balancing this with the professional autonomy that many practitioners cherish. There is no easy response to dealing with such a conundrum but the reality remains that many osteopaths, in addition to being healthcare providers, are also small business owners who need more information concerning the expectations of their patients and how they can be realistically be accommodated or, when expectations are unrealistic, how they can be managed through education and information giving.

The involvement in a commercial world means that many therapists, including osteopaths, have to deal with the competing demands and expectations of different stakeholders in healthcare. Grimmer et al., (1999) looked at the differing expectations of physiotherapists, insurers who referred patients for treatment, and the patients themselves. Value for money

was the principal expectation for the referrers who wanted rapid pain relief, education and self-management strategies to prevent a recurrence of symptoms. Therapists wanted achievement of many of the same expectations, hoping to return patients to their pre-injury state. Patients' expectations concurred with some of these aims but therapists often found that expectation of a "cure" could not be realised and dissonance was evident in the time and commitment to recovery that was expected of the patients.

The main implications for osteopathy emerging from the literature were, therefore the need for the profession and individual practitioners:

- To provide effective communication;
- To exhibit professional behaviour;
- An organised and effective service;
- Care which is attentive to the patient's concern;
- Efficient triaging with referral where necessary;
- Provision of an indication of the prognosis;
- To explicitly identify and actively understand patients' expectations in order to increase satisfaction;
- To increase their familiarity with evidence-based information that can be considered as optimum health advice which avoids raising unrealistic expectations;
- To begin to engage in goal-setting for patients based on identified expectations of outcome in order to ensure concordance and prevent unrealistic expectations;
- To document expectations and outcomes more closely with patients, perhaps using validated outcome measures and assessment tools routinely.

Chapter 3 Exploring patients' expectations of osteopathic care: a qualitative study

Summary of Chapter 3

New understanding of expectations of osteopathic patients was gained through in-depth focus groups and individual interviews with 45 participants, who were patients drawn from 16 osteopathic practices in 14 locations across England, Wales, Scotland and Northern Ireland. The practices included private practices, osteopathic training clinics and NHS services. The patients were diverse, ranging in age from 17 to 84 years, in ethnicity, and in socio-economic background. The rich, in-depth data represented over 20 hours of discussion, which were transcribed verbatim and analysed thematically to create a model specifically of the expectations of osteopathic patients.

The model of osteopathic patients' expectations comprised five broad themes, each comprising a number of topics. The five broad themes were:

(1) ***Individual agency*** *representing the patient's ability to take control of their own condition and make an informed choice about their treatment/management; their need to understand their problem, and the decision to pay for care even if financial sacrifice may be involved;*
(2) ***Professional expertise*** *representing the patient's desire to access the osteopath's specialist knowledge and manual and information-giving skills, their wider knowledge of treatment options, and professional conduct with clear boundaries;*
(3) ***Customer experience*** *representing the expectation of appropriate attitudes of staff and the therapeutic environment within the practice to build rapport, together with flexible appointment times and value for money;*
(4) ***Therapeutic process*** *representing expectations of the consultations, including sufficient time for manual treatment that impacted on symptoms, on-going care if required, and involvement of the patient if they wanted it, in treatment planning and self-management;*
(5) ***Interpersonal relationship*** *which was a theme that was recurrent throughout the transcripts, and represented being believed that symptoms were real, the development of a*

trusting relationship with the osteopath, and having a sense of connection with their practitioner.

Some unmet expectations were raised: some patients suggested that they received insufficient preparation and dialogue about the (forceful) nature of the intervention or inadequate pre-treatment information so that the experience of osteopathic "crunching", and the level of side-effects after treatment, came as a surprise. Some were unhappy about having to undress, or had not realised that it would be required. There was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this is an area of concern for patients where expectations may possibly be unmet. Some participants described previous experiences that had not met their expectations in terms of the environment (lots of cuddly toys in the room) or the relationship/ boundaries (one osteopath described as "creepy").

The themes, together with the topics sub-themes and topics within them, were all used to develop questions for inclusion in the survey questionnaire.

3.1 Introduction

This phase of the project was a qualitative study which aimed to provide a basis for development of a survey questionnaire to explore patients' expectations of osteopathy. The qualitative data analysis sought to answer the question, "What are the specific aspects of osteopathic practice about which patients have expectations?"

The aim in this phase was to elicit the views of a diverse range of patients attending private osteopathic practices, in relation to their expectations of osteopathy. The patient sample was designed for diversity of age, gender, ethnicity, health and disability, and social background, and drawn from different geographical areas, urban and rural residence, and osteopathic service models. The data were collected through focus groups and individual interviews and analysed to identify and understand the themes and issues raised by patients in relation to their expectations, using qualitative analytical methods.

Focus groups are "a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of research" (Powell, 1996) and are particularly powerful for gathering rich information and obtaining several perspectives about the same topic. Focus groups involve organised discussion (Kitzinger, 1994) to gain information about participants' views on a topic (Kitzinger 1995; Goss & Leinbach, 1996). The benefits of focus group research include gaining insights into people's shared understandings of everyday life.

3.2 Protocol

The Question schedule

The question schedule used in the focus groups and interviews was developed based on the literature review, clinical experience and a pilot focus group conducted using volunteers in the Clinical Research Centre.

Study Population

The patients eligible for the focus group interviews were those currently receiving osteopathic treatment, in one of two different osteopathic service models: private practices or

Osteopathic Education Institutions (OEIs). The eligibility criteria for the initial interviews were: currently receiving osteopathic treatment at a private clinic or an OEI clinic, an ability to speak English, capacity to consent, and aged 16 years or over.

Patients receiving treatment from osteopathic services within the NHS were included after some delay due to the need for NHS Ethical approval and local R&D approval.

Sampling

The focus groups were purposely held in geographically diverse areas in the UK. In each area, a small number of osteopaths were contacted with a view to recruiting patients. One of the research team, CF, was in regular contact with research-oriented osteopaths in these locations through links forged by the regional network of the National Council for Osteopathic Research; she helped the Research Officer (EF then LB) for the OPEn project to find a "lead" osteopath in each location who would be willing to help organise the focus group.

The lead osteopath in each location was approached initially by telephone, and later followed up by a letter. They were asked to assist with recruitment of a purposive sample of participants. The patient sample aimed for diversity of age, gender, ethnicity, health and disability, social background, and urban or rural residence.

Recruitment

The local lead osteopath advertised the focus group in their practice using a poster supplied by the research team. If they wished they could also involve other local practices in recruitment. They were asked to select and invite approximately 12 patients to participate. The patients who were interested in participating were given a participant pack comprising a letter of invitation, a participant information sheet about the study and a consent form. The consent form included some optional ethnicity and diversity questions to permit these characteristics to be collected. The patients were asked to return the consent form to the Clinical Research Centre. The patient volunteers who completed and returned the consent form agreeing to participate were telephoned by the researcher (JL or LB) to ask if they were available at the time and date of the focus group and to check eligibility. The patients were

reminded to let their GP have the extra copy of the participant information sheet, as advised by the NHS REC. The aim was to have 6-8 patients in each focus group.

Patients were recruited for individual interviews after a number of focus groups had been conducted and the data had been analysed. The individual interviews permitted more detailed questioning and exploration of specific issues that had been raised in focus groups, and that were unclear or needed more elucidation.

Organisation of Focus Groups

The Research team was responsible for arranging the place, date and time for the focus group interviews. The venue for the focus group was neutral (i.e. not the practice where the patients were treated) so that patients could feel free to voice their opinions in full. In order to increase diversity and equity of access, the timing of the focus groups varied in the different locations, from evening (for employed people) to daytime (for the elderly), and the venues included those with disability access and crèche facilities for mothers such as a local gym.

The focus groups were facilitated by a member of the research team using a schedule of topics (see Box 3.1). A second researcher was present to observe and take field notes on body language or any apparent emotional discomfort. The researcher and assistant had no prior relationship with any of the focus group participants. Participants were asked verbally to confirm they were happy for the conversation to be recorded digitally (they already had provided written agreement to this in the Consent Form). The facilitator and assistant had prior training to ensure a common protocol was used. Focus groups lasted for no more than two hours.

Box 3.1 Schedule of question prompts for focus groups and individual interviews

1. What were you expecting when you first came to see the osteopath in terms of:

   The practice environment?
   The osteopath as a professional?
   The osteopath as an individual?
   The examination carried out?
   The treatment given?
   The cost of treatment?
   The process of treatment?
   Communication with the osteopath?
   Outcome of care?
   Practice personnel?
   Other features not listed?

2. Was there anything that happened at your first appointment that you did not expect?
   -touch, undressing, privacy
3. How involved did you expect to be with decisions about your treatment?
4. Did you expect an explanation of risks and benefits?
5. Did you expect to be asked to give consent for examination and /or treatments?
6. Did your visit to the osteopath disappoint you or not meet your expectations?
7. Any further comments?

Data Processing and analysis

All interviews were transcribed verbatim by a third party. Two members of the research team (VC, APM) carried out thematic analysis manually on the interview data, using the protocol described by Braun and Clarke (Braun and Clarke 2006)and summarised in Table 3.1. The protocol makes clear the iterative and evolving nature of the analytic process.

Table 3.1 Phases of thematic analysis (from Braun and Clarke (2006))

Phase	Description of the process
Familiarisation with data	Reading and re-reading transcripts, noting initial ideas.
Generating codes	Systematic coding of interesting features case by case and across the data set; linking initial codes to GOSC Code of Practice.
Creating categories	Clustering coded extracts under categorical headings.
Searching for themes	Gathering all data relevant to each potential theme. Lifting quotes from original context and arranging under thematic headings.
Reviewing themes and thematic mapping	Checking if themes work in relation to coded extracts and total data set; identifying inter and intra-thematic relationships; generating a thematic overview of the analysis.
Defining and refining themes	Refining the specifics of each theme; generating clear definitions and names for each theme.

Both researchers identified themes independently, before coming together to compare, review and reach consensus. Trustworthiness of the analysis was enhanced further by the fact that neither VC nor APM were osteopaths by profession, enabling a detached perspective on emergent themes and interpretation, before the data were brought before the wider research team.

3.3 Findings

Within private osteopathic practices, six focus group interviews and nine individual interviews were conducted in eleven towns across the UK, including practices in Scotland, Wales and Northern Ireland. In NHS practices, two focus groups and two individual interviews were conducted within two different primary care practices in London.

Diversity Characteristics of participants

The participants in the interviews and focus groups were recruited from different osteopathic practices across the UK. Eleven sites were private practices, and two were OEI training clinics located in Hertfordshire (College of Osteopaths) and London (British College of Osteopathic Medicine), and two were NHS services located in different areas of London, as shown in Table 3.2.

Table 3.2 Locations, dates and types of focus groups and individual interviews

Type of practice	Practice Location	Date 2009	Number of participants	Type of interview
Private	Cardiff	July 2009	3	Group
	Rainham, Kent	Aug 2009	6	Group
	Glasgow	Sept 2009	2	Group
	Eastbourne, Sussex	Oct 2009	5	Group
	Midlands (3 practices)	Nov 2009	4	Individual
	Bristol	Nov 2009	1	Individual
	Exeter	Nov 2009	2	Individual
	N Ireland	Nov 2009	2	Individual
OEI	College of Osteopaths, Herts	August 2009	5	Group
	British College of Osteopathic Medicine, Finchley	Sept 2009	4	Group
NHS	Stockwell General Practice	June 2010	7	Group
	Kensington and Chelsea PCT	March 2011	2	Individual
Totals	**16 practices 14 locations**		**34 in focus groups 11 in interviews Total 45**	**8 focus groups 11 individual**

Of the 45 participants, 20% were from OEI practices, 20% were from NHS practices, and 60% from private practices. 75% of the information was gained in focus groups. The socio-economic characteristics of the participants presented in Tables 3.3 and 3.4 show considerable diversity in age, health status, and ethnicity. Some ethnic groups were not represented, notably the Indian continent, Arab countries and China.

Table 3.3 Participants in the qualitative study by age and ethnic background

Age (years) / **Ethnicity**	**16-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80+**	**Total**	*Serious health problems or disability*
White British	1		2	9	8	11	3	1	**35**	*4*
Black/Asian			1	4					**5**	*3*
White other			1		1		3		**5**	*3*
Total	**1**	**0**	**1**	**13**	**9**	**11**	**1**	**1**	**45**	*10*

The rather more detailed data gained from the 9 interview participants attending private practices (Table 3.4) shows that there was considerable diversity in terms of urban or rural residence, educational level, and the duration, severity and site of their symptoms. They tended to be rather homogeneous in terms of marital status, and their perception of their quality of life and health status as good. The prior use of other manual therapies (chiropractic and physiotherapy) was common. Some participants reported significant co-morbidity, and some reported that paying for treatment was a hardship.

The patients drawn from NHS osteopathic services participated some months later than the others, due to the protracted processes of identifying NHS osteopaths, obtaining their agreement to cooperate, obtaining approval from the NHS Research Ethical Service followed by NHS R&D Site-specific approval for the two participating sites, which were in Lambeth, London and Chelsea, London. The analysis therefore took place in two stages. The initial analysis of text data from the discussions within private practices and training clinics

produced a single conceptual model of expectation which had five main themes. The NHS textual data was analysed independently to identify any new themes or topics. It was entirely consistent with the original model as described below.

Table 3.4 Characteristics of participants in individual interviews (continued on next page)

PATIENT No.	1	2	3	4	5	6	7	8	9
Location	Coventry	Coventry	Coventry	Coventry	Exeter	Exeter	Bristol	N Ireland	N Ireland
Gender	F	M	M	M	M	F	F	F	M
Age	Over 65	58	68	64	54	44	62	41	46
Ethnicity	White British	White British	Scottish	White British	White British	White British	White British	White British	White British
Marital Status	Married	Married	Married	Married	Married	Married	Married	Married	Married
Type of area	Rural	Urban	Urban	Urban	Urban	Urban	Urban	Rural	Rural
Age Finished education	Age 16	Age 16	1st degree	Postgraduate	1st degree	Age 16	Age 16	Postgraduate	1st degree
Employment	Retired	Retired	Retired	Current job	Current job	Homemaker	Retired	Current job	Unemployed
Duration current symptoms	25 years	30 years	2 years	30 years	1 month	2 months	20 years	3.5years	Not applicable
Duration current treatment	15 years	30 years	6 months	30 years	2 treatments	1 treatment	20 years	3.5years	Not applicable
Attempted home treatment	yes	yes	no	no	yes	no	no	no	no
Time since 1sr treatment	15 years	30 years	6 months	30 years	25 years	6 months	20yrs	5 years	10 years
First visit to practice?	No	No	yes	No	yes	No	No	No	N/A
Previous chiro?	no	no	no	no	yes	yes	yes	no	yes
Prior physio?	yes	yes	yes	yes	yes	no	yes	no	no
Prior other CAM?	no	no	no	no	no	no	Acupuncture	Reiki	no

Continued overleaf

Table 3.4
continued

Location main symptoms	Low back, neck, shoulder, knee	Low back, knee	Neck	Low back	Upper back, leg	Low back, hip	Low back	Upper back, neck, shoulder, low back	Neck, low back
Severity of symptoms	Moderate	Severe	Moderate	Moderate	Moderate	Severe	Mild	Severe	Moderate
Payment method	Insurance +self	Self	Self	Self	Self	Self	Self	Self	Self
Hardship of payment	Not hard	Not hard	Not hard	Quite hard	Not hard	Very hard	Not hard	Not hard	Not hard
General health status	Excellent	Good	Fair	Good	Excellent	Good	Good	Excellent	Excellent
Good quality of life	yes	yes	yes	yes	yes	yes	yes	yes	yes
Other disability/illness	No	No	No	No	Osteoporosis	No	Rheumatoid arthritis	No	No

Generating codes and creating categories

Coding of the transcribed interviews involved identifying extracts in the transcribed text that appeared relevant in the terms of the research question stated above. Relevance in relation to the wider context of the research was also established by mapping emergent codes (extracts) against the GOsC Code of Practice clauses as shown in Appendix 7. Repeated readings of the transcripts identified aspects in the coding that could be collated into 'categories' across the data set.

Searching for themes

This phase refocused the analysis at the broader level of themes, clustering different categories into potential overarching themes. All relevant coded extracts were then collated under relevant thematic headings. As an example, Box 3.2 illustrates how the overarching theme 'interpersonal relationship' was derived from, and rooted in, the raw transcript data. The complete set of themes and a range of their associated categories and codes are included in Appendix 6.

Reviewing themes and examining relationships

This phase examined how the themes fitted together and the interrelationships between them. The purpose of this phase was to establish the coherence of the analysis in relation to the research question. Figure 3.2 shows diagrammatically the relationship between the themes at this stage of analysis.

In Figure 3.2, the five overarching themes appear in bold. Solid lines indicate some links identified between intra-thematic categories; dotted lines indicate links between themes.

Defining and refining themes

The purpose of this phase was to organise themes into an internally consistent account. The final thematic map (Figure 3.3) shows the five themes and the categories that were coded within them together with indicative links to its transcript extracts. The categories making up each theme are described below, followed by illustrative verbatim quotes for greater understanding.

Box 3.2 The relationship between coded extracts, categories and themes

THEME: INTERPERSONAL RELATIONSHIP

CATEGORY 1: Sense of connection

Coded extracts:

"…you've got a more relaxed atmosphere…a connection between the two of you."

"They (NHS) say 'Oh yeah you want a course, you want to do this...' the hydro and all the rest of it…but once you've done that course with them they don't want to know you."

CATEGORY 2: Placing trust

Coded extracts:

"I think you just trust him. If he says I'm going to try this, you trust him that that's the right thing, because you have complete faith in him."

"I think if you have a good osteopath there's no risk whatsoever in what he does…when people say…'you could end up quadriplegic', I say 'Absolute rubbish!"

"If I have sufficient confidence in the practitioner…then I don't expect he would have to go into detail (discussing risk) because that could take away the confidence the patient has.. and that would be a bad thing."

Figure 3.2 Reviewed themes and relationships

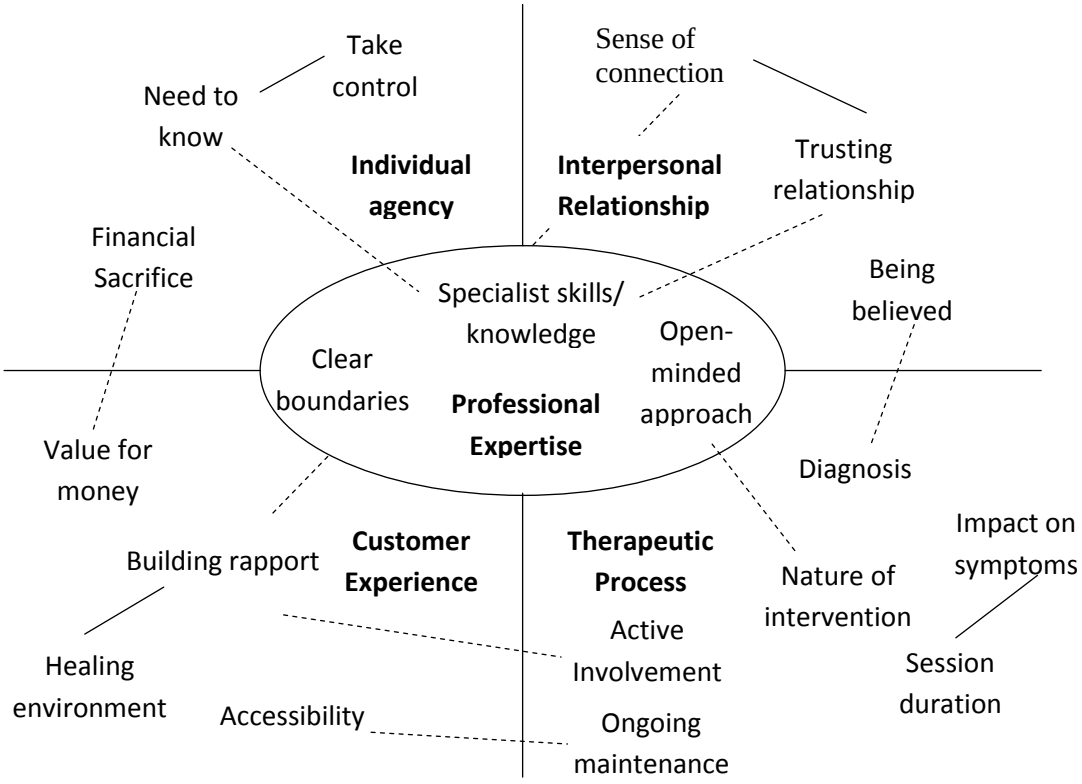
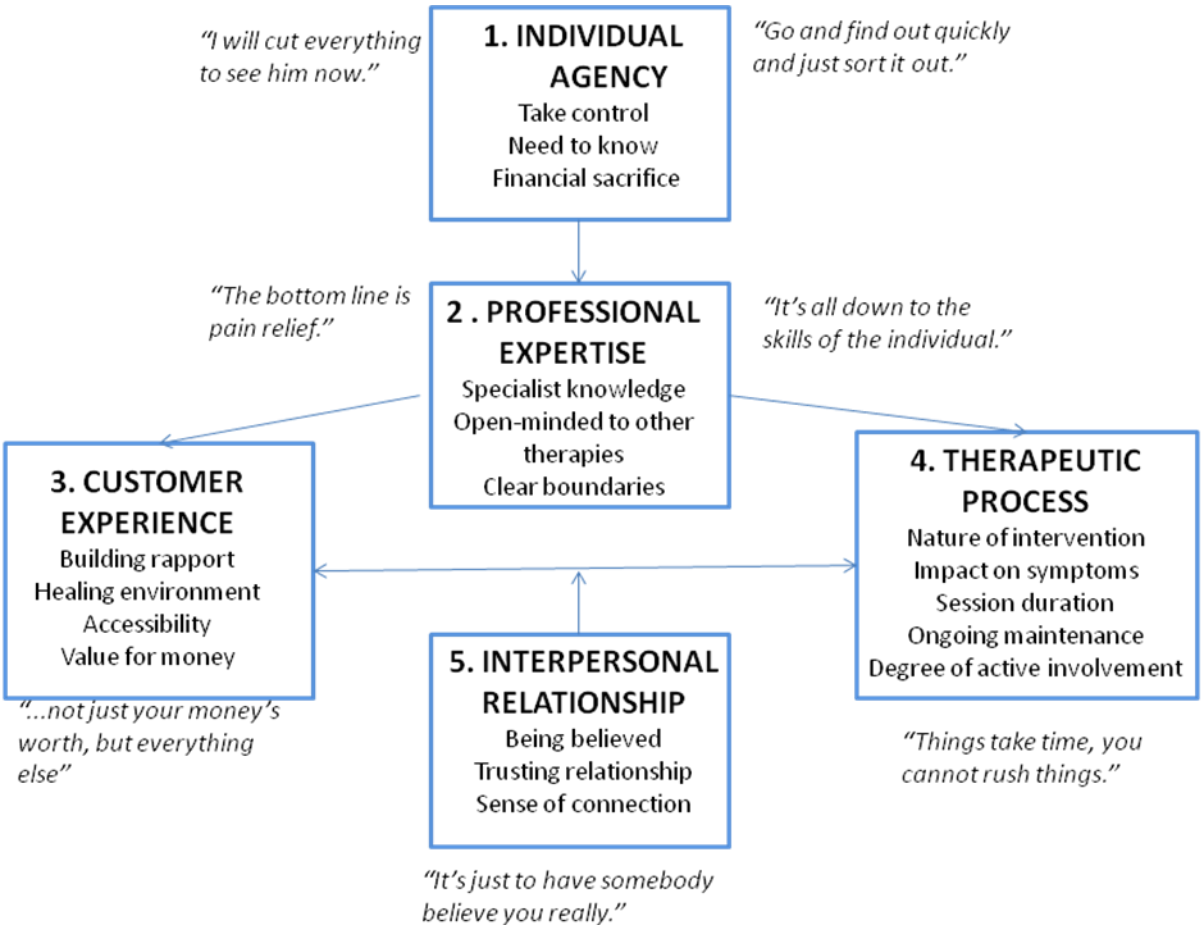


Figure 3.3 Final thematic map of patient expectations



3.4 The categories comprising each theme

The five themes in Figure 3.3 include a number of categories within them. To aid understanding, these categories are described in brief and then, in the next section, illustrative quotes are given for each theme and category.

THEME 1 - Individual Agency

1 (i) Take control

Consulting with an osteopath was seen by patients as enabling them to take control of their own condition, to feel empowered through information to help themselves and to feel someone professional was in control of the situation.

Patients also expected the planned treatment to be explained in order for them to decide whether to proceed with treatment.

1(ii) Need to know

Patients expected to understand, through information given by the osteopath, what their problem was and why it may have occurred. They also needed confidence that the problem would be assessed correctly by an appropriate person. They expected to develop knowledge of the problem in order to gain some reassurance that the problem could be dealt with.

1 (iii) Financial sacrifice:

Patients expected to have to pay for treatment and were also philosophical about enduring a financial sacrifice if necessary to improve their physical situation.

THEME 2 – Professional expertise

2 (i) Specialist knowledge and skill

Patients expected osteopaths to have knowledge and skills to reduce pain and to deal with problems affecting joints and muscles. They expected osteopaths to be able to reduce stiffness and soreness and expected a high level of manual skills.

2 (ii) Open-minded approach

Patients expected osteopaths to recommend other treatments with other health professionals if necessary and to be treated holistically. They also expected osteopaths to be understanding of the range of problems they were facing in their life.

2 (iii) Clear boundaries

Patients expected a professional approach, particularly with regards to touch which should also be accompanied by appropriate explanation, especially in the situation of a male osteopath treating a female patient. It was expected that osteopaths would behave as professionally as general practitioners and would exhibit exemplary professional behaviour in situations where people may feel vulnerable e.g. in the state of undress.

Patients also expected an explanation that states of undress during examination and treatment may be necessary, before arrival at the surgery or on arrival at the surgery.

THEME 3 – Customer experience

3 (i) Building Rapport

Patients expected that the osteopath and/or receptionist would be personable, friendly and welcoming. They expected a clean and comfortable treatment environment.

3 (ii) Healing environment

Patients expected a relaxing, holistic and healing environment within the osteopathic practice setting.

3 (iii) Accessibility

Patients expected timely appointments with short waiting times and flexibility of appointments to suit needs.

3 (iv) Value for money

Patients expected that paying for the service would mean that they received care tailored to their wants and needs. They also expected additional services, for example follow-up care, and did not expect to be pressurised to make future appointments. Patients did not expect to have to return for treatment unless absolutely necessary.

THEME 4 - Therapeutic process

4 (i) Nature of intervention

Patients expected more soft tissue massage than manipulation and most patients expected their examination to include a visual examination, and a manual examination followed by manipulation. Patients also expected that treatment would not necessarily work the first time and they expected gentle but firm treatment.

4 (ii) Impact on symptoms

Patients expected pain relief and return of normal movement following treatment, but some expected the pain to increase and stiffness to increase for a day or so after treatment with then subsequent improvement. Some patients felt that it might take two to three visits for a condition to improve. Some patients felt that the interval between treatments should widen to reduce costs ultimately.

4 **(iii) Session duration**

Patients expected duration of treatment sessions to be flexible according to need, often an hour for a first consultation to enable a full examination and relevant information-giving.

4 **(iv) Ongoing maintenance**

Many patients expected routine maintenance once a week, every six months or once a year, depending on the problem.

4 **(v) Degree of involvement**

Patients expected the osteopath to have a plan of action with regards to treatment and management. The majority of patients felt that they should have an explanation about possible treatments and treatment choices, and to be involved in this decision making process, but some patients were very happy for osteopaths to take control of their treatment solely.

Patients did expect, however, to be listened to when they were talking about their condition and how it was affecting their body. They also expected to get some understanding of their problem and expected to be able to ask questions of the osteopath in relation to their problem and the defined treatment. Some patients expected to be involved in treatment, for example doing exercises at home, but some patients, were not sure about taking responsibility for their own condition and felt that they should leave this to the osteopath.

THEME 5 – Inter-personal relationships

5 (i) Being believed

Patients expected and desired osteopaths to understand the impact of the problem on them as individuals and to take the problem seriously.

5 (ii) Trusting relationship

Patients expected to be able to trust their osteopath and their decision making processes. They also expected to have treatment risks pointed out to them if there were any. However, many patients did not feel there was much associated risk with their treatments. Patients felt that assurance should be given when treatment was feeling uncomfortable and they expected to

have confidence in their practitioner. Some patients did not necessary expect to give consent for treatment, they felt that attending the clinic in itself implied consent.

5 (iii) Sense of connection

The benefit of private treatment was that more time was available than within the NHS; having more time meant that there were more opportunities for the individual patient and the osteopath to develop a sense of connection and long-term relationship. It was more possible for the osteopath to convey their sense of caring to the patient, particularly about treatment outcomes.

3.5 Illustrative verbatim extracts for each Theme

The five themes are elaborated below using a range of illustrative verbatim extracts from the focus group and individual interview transcripts. The extracts are shown in italics; brackets indicate where words have been inserted to enhance clarity of original text; (…) indicates that text has been condensed for brevity, without detriment to meaning.

THEME 1: Individual agency

Perceived lack of information from other practitioners generated a need in participants to take control of the situation (Category 1i) in order to receive a diagnosis and find a solution quickly (Category 1ii), *"You need someone to stop you worrying, don't you?"* Thus, the theme 'individual agency' (ability to take control and make a choice) represented an expectation that the osteopath would know and explain the cause of symptoms when others had failed to do so.

> *"…on the first visit (the patient) will understand what their problem is."*
> *"Not only that but to find out why you've got pain."*

That this would involve financial sacrifice was a concomitant expectation, but this was considered a sacrifice worth making (Category 1iii).

> *"It's over half my wages, but… if I've got to pay that every week, or every other week, for the rest of my life, to feel how I'm feeling now (I will)."*

THEME 2: Professional expertise

The rationale for visiting an osteopath was also based on perceptions of the focus of osteopaths' expertise and their level of related knowledge (Category 2i) when compared to other professionals.

> *"You don't go to an osteopath unless you have pain."*
>
> *"…any kind of stiffness and soreness the osteopath will automatically be able to fix me."*
>
> *"Physios and doctors, they don't know enough about the actual knowledge-base - skeletal, the muscles and things like that."*

This valuing of specialist knowledge was reinforced by the osteopath's ability to make it accessible to patients, *"I was thinking, that's so simple! Your balance, your centre of gravity changes."* At the same time, participants were reassured by the expectation that the osteopath was open-minded enough to consider other approaches, and would readily refer patients to other professionals if it was considered warranted (Category 2ii), *"If it's not the osteopath's problem, they will be speedily directed elsewhere, and that's the main thing I'm looking for at the beginning, understanding."*

At times participants were disparaging about their experiences with General Practitioners (GP) *"Take painkillers and get on with it, you know, that was her GP's attitude." "They just refer you back to your GP and the GP's got no idea."* Nevertheless, GPs were held to be the benchmark in terms of maintaining expected professional boundaries (Category 2iii), *"He treats you as a patient and you treat him as you would your GP…he's a doctor, that's how you've got to think of him".* However, this was not sufficient to offset a view that patients should still be forewarned of the potential need to undress, *"…to have it explained to you first, before you initially walk in, instead of having it sort of sprung on you."*

THEME 3: Customer experience

This theme focused on elements of 'service process' as opposed to 'service outcome'. Building rapport (Category 3i) was an important starting point, from a positive first impression, to personalised communication and a feeling of being heard.

> *"God help us and save us all from doctors' receptionists…so I thank goodness that, you know, osteopaths have receptionists that aren't that bad."*

> *"Yeah and they* (Osteopaths) *fit whatever you say in and when he's finished, it's not 'Oh get up, get dressed, get out', he talks to you and says what's going to happen and how long…and he explains things."*

Closely linked to this was the sense of walking into an environment (Category 3ii) that was more *"holistic"* than *"clinical"*.

> *"I think they try to create…a healing environment. You want to walk into somewhere that is going to feel relaxing and comforting for your feelings before you go into your treatment."*

But the *"…confident expectation of being helped to be well"* was, to some extent contingent upon the help being available as and when required (Category 3iii). *"(Osteopaths are) freer to deal with patients as and when the help is needed, which is what any sort of treatment of patients should be all about."*

As mentioned above, financial sacrifice was, potentially, a feature of the customer experience. This financial outlay was allied to expectations of value for money (Category 3iv) and, in terms of service process, more than could reasonably be expected in the NHS.

> *"I think it is because you're paying and it makes a difference, you're paying for a service, but you expect not only just your money's worth, but you expect everything else, the follow-up and the care that goes with that as well."*

At the same time, participants were alive to the possibility of exploitation, *"I never feel pressured to make another appointment or like I'm being fleeced."*

THEME 4: Therapeutic process

While some expressed uncertainty or surprise at the nature of the osteopathic intervention (Category 4i) others were unambiguous.

> *"…all the crunching business on the back, that took me by surprise…because I really didn't know they did that."*

> *"I would expect to describe my problem, be examined visually, to be examined manually, and then manipulation to put back whatever's misplaced."*

> *"Well what I expected… is manipulation and probably a good deal of relief on my first one."*

In terms of impact on symptoms (Category 4ii), this might occur immediately or after several treatments, but *"The bottom line is pain relief".* However, the treatment itself might *"leave you very sore afterwards,"* temporarily. Time was a notable feature in perceptions of the therapeutic process. Thus, while it was acknowledged that, *"…things take time, you cannot rush things like that",* in the short-term, the duration of individual sessions (Category 4iii) was expected to be sufficient to fulfill other expectations such as the patient's acquisition of knowledge and understanding, and hands on treatment as well as examination and assessment at first contact.

> *"And a session of half an hour or so, there is time to explain everything, which the doctor doesn't have time or even that intricacy of training."*

The notion of ongoing maintenance (Category 4iv) reflected a long-term perspective that could be seen as linking back to the initial theme of individual agency, by avoiding worry and staying in control.

> *"…I'd rather go back say in six months if I had treatment, just, you know, just to make sure everything is right before it flares again."*

> *"I think you'll want to go back even if you're (OK) just for a sort of check up every year or something like that."*

(Category 4v): 'Degree of involvement' encompassed other aspects that linked back to earlier themes. The rapport valued during the initial service encounter was elaborated further in terms of the ongoing therapeutic process (Category 3i), but there were interesting differences in participants' expectations. On the one hand there was an expectation of reciprocity that facilitated knowledge transmission (Category 2i), mutual understanding and cooperation. However, there was a price to pay for this in terms of session duration (Category 4iii).

> *"(The osteopath) actually listens to what I've got to say about my body, because obviously I know it, and then he puts his professional opinion on it, because obviously he's trained to know these things. So he takes what I say on board and then explains it. And he tells me everything he's doing, so if I don't understand*

it I can ask him questions and he'll tell me. So I quite like that, and expect that from him."

"I tried to get him to explain how things occurred as to, if it's in a strain or anything like that, if something else moved, what on earth I did to go and cause it, and quite a few times it did used to come down to certain things I'd never dreamed it would come from."

"So it's like you're involved…He explains that you understand and then he says, " If you don't understand, just ask". So normally I'm running over half an hour."

In sharp contrast, other participants deemed such a level of involvement as unnecessary and inappropriate. This view also extended to possible expectations of involvement in self-management beyond the immediate therapeutic encounter.

"If I have sufficient confidence in the osteopath, or whoever, then I don't expect that he would have to go into detail because that could take away from, you know, the confidence that the patient has in the osteopath, and that would be a bad thing."

"I think their remit as an osteopath is to treat people not to get you to treat yourself. You know, you're paying for treatment."

THEME 5: Interpersonal relationship

The foregoing expectations could be seen as implicit in three key elements of interpersonal relationship between patient and osteopath. To be believed and taken seriously (Category 5i) justified the decision to consult an osteopath and the associated expense, *"…people don't always believe you because there's nothing physical"; "…and he doesn't judge you either."* Faith in the osteopath's expertise was the basis of a trusting relationship. For some this obviated any need for discussion of potential risks and dismissal of warnings from sceptical others (Category 5ii).

"I think you just trust him. If he says I'm going to try this, you trust him that that's the right thing, because you have complete faith in him."

> *"I think if you have a good osteopath there's no risk whatsoever in what he does…when people say…'you could end up quadriplegic', I say 'Absolute rubbish!"*

Finally, the potential for a long-term connection was expressed in terms of a caring approach to the individual over time and the door remaining open (Category 5iii).

> *"…in the NHS I think because of the pressure...once you've done that course with them they don't want to know you."*
>
> *"(The osteopath) cares that you've got an outcome."*

3.6 Analysis of the NHS data

The two focus groups and two interviews with NHS patients were conducted some months later than the other interviews. The transcripts were analysed as described above. No new topics or themes emerged from these data,; the model appeared to apply to NHS as well as private patients, despite the fact that the patients' socio-demographic, ethnic and health characteristics differed from private patients, and the context in which the patients exert their individual agency and gain access to professional expertise was different. The triangulation provided by the NHS analysis adds validity to the model of expectations.

3.7 Discussion and summary of qualitative data analysis

The themes and categories derived and shown in Figure 3.3 represent robust, rigorously derived new primary data. The framework developed here was patient-centred and specific to the expectations of patients consulting osteopaths in the UK. The findings not only identify numerous aspects of expectation for osteopathic patients but also provide a conceptual framework within which to understand those expectations. The framework reflects the complexity of the clinical encounter within osteopathy.

Patients' expectations of osteopathic care

While many of the expectations identified in this qualitative phase of the study were consistent with the previous evidence from the literature, mainly derived from other areas of health care, there were also some novel findings (underlined in the list below):

Patients' expectations of osteopathic practitioners were that:

- seeing an osteopath would allow them to gain control of their problem;
- the osteopath would provide an explanation and help them understand their problem;
- they would gain control over their pain even if it involved financial sacrifice;
- the osteopath would have specialist knowledge and skills of their musculo-skeletal and related health problems;
- The osteopath would have a wider knowledge of other types of health care, including complementary health care, and links for referral purposes and advice to other healthcare professionals;
- They could trust the osteopath to behave in a professional manner with clear boundaries;
- The practice would offer flexibility in appointment times, and see them quickly if they were in severe pain;
- The service offered would be flexible and value-for-money, delivered in an environment that promoted rapport-building and healing;
- The duration of consultations would provide sufficient time for thorough examination, diagnosis and manual treatment;
- The treatments would be spaced at appropriate intervals to improve symptoms;
- The osteopath would provide an estimate of the likely course of treatment and outcome, for example, the number of treatments that might be required before relief of symptoms;
- The osteopath would provide treatments that were effective and reduced the patient's need for medication;
- Patients would not be exploited by being given treatment when there was little chance of improvement, or being advised to return for unnecessary follow-up;
- On-going maintenance treatments would be offered as an option, if required;

- Patients would be involved in planning treatment and in self-management, if they wished;
- A trusting inter-personal relationship with the osteopath would be possible, with the osteopath believing them, taking their problem seriously and caring about the outcome, and the patient having confidence in the practitioner.

There were some unexpected findings within the data. Starting at the first theme of individual agency, the strength of patients' views about financial sacrifice was an unexpected finding. In Theme 2, professional expertise, the appreciation of open-minded discussion about other therapies was identified; and the bench-marking against GPs in terms of respect for clear boundaries also emerged very clearly. Within Theme 3 (Customer experience), was the desire for a healing environment, the need to forewarn patients about the nature of osteopathic treatment; and the expectation of a better service quality than the NHS is able to provide when the client is paying.

The findings confirmed the importance patients attached to session duration, both as value for money and as providing time to explain and educate the patient about their symptoms; and endorsed the provision of on-going maintenance for patients who would otherwise worry about their health and for those who want a long-term sense of connection with a "door remaining open".

The importance of understanding the individual patient emerged clearly, especially as there was a divide between patients who wanted to trust the practitioner, even to the extent of disbelief about any risks, and patients who wanted active shared decision making; and between patients who wanted to be actively involved in self-management alongside treatment and others who believed they were paying for the practitioner to get them better.

Unmet expectations of osteopathic care

The patients that agreed to take part in these interviews tended to be enthusiasts in favour of osteopathy, so it is unsurprising that few criticisms of osteopathy emerged. However the following issues were raised.

Within theme 4, Therapeutic Process, some of the quotes from patients suggested that they received insufficient preparation and dialogue about the (forceful) nature of the intervention or inadequate pre-treatment information so that the experience of osteopathic "crunching", and the level of side-effects after treatment, came as a surprise. Some were unhappy about having to undress, or had not realised that it would be required.

Within theme 3, Customer Experience, there was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this is an area of concern for patients where expectations may possibly be unmet.

Some participants described previous experiences that had not met their expectations in terms of the environment (lots of cuddly toys in the room) or the relationship/ boundaries (one osteopath described as "creepy").

Implications for the profession arising from the qualitative phase of the study

For the professional osteopath, the above findings have clear implications about what is needed within the delivery of the osteopathic service:

- recognition that patients seeking osteopathic care want to gain control over their problem; they may already know a lot about their problem, may well have consulted doctors and other manual therapists previously, including osteopaths, and may have preferences about the sort of osteopathy they want to receive;
- prior information for patients about the reasons for undressing;
- more details about the nature of the osteopathic intervention at an early stage in the pathway;
- a good explanation of causes at the first visit, and relief of symptoms within a reasonable timeframe;
- empowerment of the patient to take control themselves, where possible, for example with home exercise or advice;
- appreciation of the vulnerability imposed by suffering and by financial sacrifice if that is necessary;

- the practising osteopath having a broad knowledge of other types of health care and links with other healthcare professionals for referral purposes (this is quite challenging especially for newly-fledged practices as local links to other health care professionals take time to forge);
- maintenance of clear boundaries especially in respect of undressing, and around the intimacy of touch which is frequently required. The intimacy of contact during osteopathic treatment places a huge responsibility on the practitioner for maintaining a professional manner; patients held up GPs as the benchmark in this respect;
- awareness of the way the practice is organised, and the training of staff and osteopath in customer care, the atmosphere within the practice, and the dialogue around payment and frequency of follow-up are all important to patients; if these expectations are met, then this will contribute to both satisfaction and clinical outcomes;
- patient confidentiality within the practice, respected by all staff including receptionists;
- patients being given realistic expectations about the impact of treatment on their symptoms;
- the practising osteopath exercising good judgement about risks, for patients who want to trust the osteopath to make decisions about treatment;
- discussion of patients' preferences for and attitudes to involvement in their care;
- emphasis on the importance of each osteopath developing and maintaining communication skills, maturity, empathy and psychological balance in professional interactions with patients.

Some of these expectations have clear implications for **professional training and for CPD.** Training and support is required beyond osteopathic technique and professional practice, particularly in the following areas:

- Inter-personal skills;
- Judgement of clinical risks;
- Professional conduct and boundaries in respect of touch and clinical examination; perhaps incorporating aspects of medical clinical training, to develop a "GP-like" approach to touch;

- A broad knowledge of other types of health care and how to forge links with other healthcare professionals for referral purposes.

Limitations of the findings

It was a limitation of the study that the views expressed in the qualitative data were predominantly those of white British users of osteopathy, and there was insufficient data to identify similarities and comparisons in perspectives across different ethnic categories. This is a possible focus for any future work. In addition, the majority of participants were long-term users of osteopathy services. Hence, recall of their initial expectations may have been coloured by their subsequent experience.

Although the experience of NHS users was somewhat different, and they trended to have more severe health conditions, the five component model appeared to be equally applicable to NHS osteopathic services. Recruitment of research participants in the NHS was much more difficult (the consent rate was about 3-5%), possibly due to low literacy, low fluency in the English language, or inability to take time off work. Their expectations of customer service, such as flexibility or a pleasant environment, were tempered by their experiences of other NHS services and the fact that the osteopathic service was free. Their ability to exert individual agency, choose a professional they like, or seek professional expertise was limited within the NHS, but most participants had actively sought expert treatment for their problem within and outside the NHS.

Reflexivity and trustworthiness of the data

The focus groups and individual interviews were conducted by individuals who had considerable experience of focus group facilitation and who also came from clinical backgrounds in osteopathy or physiotherapy. An interview schedule, determined at the start of the project, guided the direction of the interviews but the focus group facilitators were free to trigger fuller responses from participants for clarification as they felt appropriate and also steered the discussions back to the interview schedule when necessary. Analysis of the interview transcripts was carried out by VC and APM, who come from backgrounds in physiotherapy, VC having specialized in neurological physiotherapy and APM in neuro-

musculoskeletal physiotherapy. Having clinical backgrounds may have influenced how the researchers interpreted and themed the data. However, having some professional experience outside the field of osteopathy was seen as an advantage as it enabled the data to be analysed within a wider context, whilst also providing some distance from the subject area.

It is likely that past clinical and academic experiences of the researchers will have influenced how they viewed the data but, interestingly, there were very few differences in the codes and categories identified in the data by the two researchers, who separately analysed the data thematically and then met to discuss coding and to draw together the emerging themes.

Future research

This phase of the study provided both new insight and understanding of the expectations of osteopathic patients, and identified a large number of topics as potential questions for the questionnaire to be used in the next phase of the study, the national survey. The conceptual framework generated here can be considered as a new model of expectations, which requires testing in future research. Using the same type of methodology, further interviews and focus groups would target specific populations and compare and contrast findings of the analysis. Further data collection could be carried out with patients drawn from different populations:

- Private practices in different locations within the UK;
- Private practices in catchment areas with greater ethnic and social diversity;
- Private practices targeting non-returners in order to investigate sources of dissatisfaction and unmet expectation;
- The less common osteopathic service models – Osteopathic Educational Institutions and NHS services;
- The general public, in order to access people with no experience or adverse experience of osteopathy;
- Osteopaths - in order to compare their expectations of the service with those of patients;

- The topics discussed within further interviews could be expanded to provide further exploration of the unexpected findings identified above, and to gain more understanding of unmet expectations.

Chapter 4 National survey of patients' expectations of osteopathic care

Summary of Chapter 4

The aim of the third phase of the study was to evaluate osteopathic patients' expectations and the degree to which they were met. A national survey was conducted, distributing a specially designed questionnaire to a representative sample of patients attending 800 osteopathic practices. This part of the study was restricted to private practices, to make the sample more homogeneous and representative of the most common type of osteopathic service.

A random sample of 800 osteopaths was created from the Statutory Register provided electronically by GOsC. The total number of osteopaths on the register was 4,039; the sample of 800 was selected proportionately and comprised 748, 4, 28 and 20 osteopaths in England, Northern Ireland, Scotland and Wales respectively. Each osteopath was asked to invite 14 consecutive eligible patients to take part in the survey. 11,200 questionnaires were mailed out in total.

A total of 1701 questionnaires were received from patient. The overall response rate was 15.2%. The rate of participation of the osteopaths was 259 out of 800 (32.4%); hence it is probable that no more than 3,626 (259 x 14) were distributed to patients. representing an estimated patient response rate of 46.9%. Of the 1,701 questionnaires received, a total of 1,649 were included in the analysis.

Over 96% of the 1649 respondents were satisfied or very satisfied with their osteopathic care, and only 0.3% were unsatisfied, providing a very positive message for the profession. The top expectations which emerged were, firstly 5 statements that respondents <u>strongly</u> agreed with, namely that they expected:

- *the osteopath to only treat one patient at a time;*
- *to be reassured that the information they were asked to provide would be kept confidential;*
- *the osteopath to take a detailed account of their clinical history;*
- *to be treated with respect;*
- *the osteopath to listen to them.*

Secondly, respondents named their "most important expectations", in their own words, and the six <u>most important expectations</u> were:

- *to have an immediate, perceptible improvement in symptoms;*
- *for the osteopath to be caring and listen to what I have to say;*
- *to be able to return to their normal activities/have an improved quality of life;*
- *to be given advice on how to manage their problem and prevent recurrence/ worsening of symptoms;*
- *to be given a clear and honest explanation of their problem and what can be achieved;*
- *for their problem to eventually resolve completely as a result of the treatment;*
- *to receive appropriate, effective treatment.*

The free text questions, some patients mentioned unexpected treatment modalities such as acupuncture (N=33), cranial osteopathy (20) and ultrasound (8).

The following were the best met, with less than 1% of respondents having unmet positive expectations:

- *To be treated with respect;*
- *To be able to ask questions;*
- *For questions to be answered to their satisfaction;*
- *The osteopath to listen to them;*
- *The osteopath to be sympathetic towards their problem;*
- *The osteopath to make them feel at ease;*
- *The environment to be hygienic and professional;*
- *The osteopath to examine their specific problem area with her/his hands;*

- *The osteopath to write down their personal case history;*
- *The consultation to last at least thirty minutes;*
- *To be given an explanation of the cause of their problem that they were able to understand;*
- *Their treatment to be value for money.*

The worst met expectations were:

- *To be made aware that there was a complaints procedure should they need to use it;*
- *For there to be communication between their osteopath and GP about their problem;*
- *To be informed of the risks and side effects of treatment;*
- *For there to be access for people with disabilities;*
- *For the osteopath to be able to refer them elsewhere when their symptoms did not improve;*
- *To be asked about the effects of previous treatment;*
- *For the osteopath to assure them that their details were kept confidential;*
- *To be given the opportunity to receive advice from the osteopath over the telephone;*
- *Before their first appointment to be given information about what would happen during treatment;*

The patient characteristics collected showed that respondents were rather homogeneous with respect to educational level, ethnicity (white) and employment status. Homogeneity increases the robustness of the findings but limits their generalisability to non-white or socially less advantaged groups.

4.1 Introduction

The aim of this third phase of the study was to evaluate and quantify, in a large representative sample of osteopathic patients, the extent of agreement with and relative importance of the different aspects of expectation identified in the previous phases of the study, and to quantify the extent to which positive expectations were met. The chosen methodology was a questionnaire survey, as this permitted the views of a large sample of osteopathic patients to be obtained economically and quickly. As the literature review had shown that no suitable questionnaire instrument existed, a new questionnaire was developed. This chapter reports on the development of the questionnaire, pilot testing of the instrument, the design and execution of the survey, and the method and results of the analysis.

4.2 The Questionnaire Development

The literature review in Chapter 2 provided some guidance on existing questionnaires in this area: the existing validated questionnaires such as the CAMBI treatment beliefs instrument (Bishop et al., 2005), the CARE measure of patient centred consultation (Mercer, 2004) and the Credibility/Expectancy Instrument (Devilly et al., 2000), which limits expectation to beliefs about symptom improvement, were principally measures of outcome rather than expectation. These instruments were designed to explore issues such as patients' beliefs about self efficacy, wellbeing, beliefs about treatment, beliefs about illness, and coping strategies, rather than their expectations of care, and were not considered appropriate for the main questionnaire although they did provide some possible topics for inclusion in this study. Previous research had demonstrated the complexity and instability of patient expectations and recommended that expectation should be measured in as homogeneous a population as possible (Staniszeweska, 1999); and that in order to elicit unmet expectations in full, patients should be given a long list of potential expectations.

The development of the questionnaire was guided by evidence on good practice (Boynton 2004; Boynton and Greenhalgh 2004) as well as more general texts (Fowler ; Fink 1995; Fink and Kosecoff 1998; Sapsford 1999; Punch 2003). The framework from Punch provided the conceptual stages in the questionnaire development; Punch (2003) defined nine general steps of developing a questionnaire, including the development of a hierarchy of concepts, phrasing of items and questions, and various levels of pilot testing.

The topics covered by the questionnaire

The core concept or topic was the patients' expectations of their visit to the osteopath. This concept included exploration of osteopathic treatment and care, outcomes of treatment, communication, anticipated costs of treatment and care planning. The topics to be explored within the questionnaire were based on these five areas and were derived from a wide range of sources:

1. Evidence from osteopathic studies of expectations, beliefs and satisfaction;
2. The full literature review of expectations in health care, including topics within published questionnaire instruments;
3. The topics raised by osteopathic patients in the focus groups and interviews;
4. Topics raised in the focus groups held by the British Osteopathic Association within their "Common Language" project (M Watson, personal communication);
5. The Osteopathic Code of Practice (General Osteopathic Council 2005);
6. Suggestions from GOsC staff;
7. Issues identified in the NCOR3 study of patient complaints against osteopaths (PI was J Leach);

The literature review in Chapter 2 had identified specific patient characteristics which were likely to affect expectations, including ethnicity, culture, age, socio-economic factors, work status, vulnerable patients and carers, prior experience (of NHS and CAM), motive for seeking treatment, the health condition they have and the extent of their desire to understand it, and treatment beliefs especially in CAM users.

All the topics from the above sources were listed, grouped, and mapped against the osteopathic Code of Practice, to ensure that all relevant aspects of the code were covered. The full mapping of topics against the Code of Practice is shown in Appendix 7.

Format of questions

There were two issues to be resolved in relation to format of questions: how to word the questions about expectation, and what kind of response options to use, including the use of a categorical or continuous scale or free text.

The word "expectation" has a complex meaning. The literature review highlighted the different forms of words that had been used in previous instruments enquiring about the complex issue of expectation: previous instruments had chosen to explore values and desires (how important?), wants and needs (do you like/ need...?) what is likely to occur or is reasonable to expect, preferences, and intentions (did you intend..?). These are all somewhat indirect. The research team decided that the wording should reflect the research question directly and ask "did you expect..?". This left the interpretation of the word for the patient to decide themselves. The individual statements (or questions) were kept short and simply worded; each question only contained one item of interest; and negatives and double negatives were avoided.

A rating scale permitting responses from "strongly agree" to "strongly disagree" was chosen as the preferred format of the questions about expectation. The reasons were that rating scales are easily understood by patients, quick to complete, and suitable for non-parametric statistical analysis (Boynton and Greenhalgh 2004). Rating scales also produce more information and more variance than other types of response (Punch 2003) and a 5-response scale was preferred to a 7-response scale on both statistical and user grounds as being more meaningful. Moreover, the respondents would be more likely to answer the questions the same way if completing the questionnaire for a second time. The format needed to be meaningful, so that respondents could confidently and quickly select the appropriate response.

Additional questions were included in order to provide the minimum essential information about the characteristics of the respondents (e.g. age, sex, prior CAM use); these were made as structured and as simple as possible. Dichotomous and scaled responses were included. A small number of open questions were included in order to permit respondents to add in free text any additional issues that they felt were missing from the questionnaire.

Format of the questionnaire

The questionnaire was conceptually divided into three sections: 1) demographic information; 2) patients' expectations; and 3) the actual experience of the patient during the visit to the osteopath.

The socio-demographic section included patient characteristics identified as relevant to expectation in the literature review and included age, ethnicity, work status; prior experience of osteopathic treatment; and severity of current symptoms. The expectation section comprised a considerable number of statements about different aspects of care, about which the patients were asked to rate the extent of their agreement or disagreement. The experience section mirrored the previous one, and aimed to establish whether their expectations were met. A short final section invited the patients to provide, in their own words, their views on their care.

The first drafts of the questionnaire were prepared in Microsoft Word. The final stage of professional graphic design, including choice of layout and colour, was reserved for the final version after pilot testing.

Pilot testing of the questionnaire

Several stages of pilot testing were employed. The first pilot tested comprehensibility, flow, and readability. The second pilot tested the face validity of the questionnaire. Finally, a statistical factor analysis was conducted on the data from the third pilot, in order to eliminate repetitive and redundant questions.

For the first pilot, osteopathic practitioners employed in the Clinical Research Centre were invited to forward the draft questionnaires to a few patients, for comments on language, clarity and readability of the questionnaire.

A second draft of the questionnaire was used to test face validity. The aim of this second pilot was to explore responses to individual items and inter-item relationships, and to identify unsatisfactory items which needed to be modified, replaced or deleted. Ten patients provided feedback at this stage, which highlighted a few areas of ambiguity or confusion. The questionnaire was revised considerably, improving the clarity of wording, and the flow of the questions. The language was checked by the study statistician (MH) who is also an expert in questionnaire design. This stage also permitted a realistic estimation of the time that patients took to complete a questionnaire (15-20 minutes).

The final pilot aimed to collect sufficient data for a factor analysis (Gorsuch 1998). Data from more than 30 patients was required. Thirteen osteopathic practices were contacted by telephone and formally invited to assist with piloting the questionnaire. Of these, ten practices were able to participate. Each osteopath was sent 8 patient questionnaire packs, comprising a copy of the questionnaire, together with an invitation letter for the patient, an information sheet about the study, and an address-paid envelope. Of the 80 questionnaires provided to the osteopaths for distribution, 32 (40%) completed questionnaires were returned by patients to the researchers, providing an estimate of the survey response rate. The data were input into a database which permitted a realistic estimation of the time taken to enter each set of data onto the database.

Factor analysis was undertaken by the study statistician (MH) to determine if any of the questions were redundant and to determine a hierarchy of importance of the questions. Factor analysis (Gorsuch 1998) is performed by examining the pattern of correlations (or co-variances) between the observed measures. Measures that are highly correlated (either positively or negatively) are likely influenced by the same factors, while those that are relatively uncorrelated are likely influenced by different factors. The factor analysis confirmed the appropriateness of all the questions. No questions were deleted or replaced.

A final review of the questionnaire was conducted by the steering group which provided a few further improvements in wording prior to the graphic design stage.

Layout and design of the questionnaire

A number of questionnaires used in large scale surveys (an educational survey by the Open University; and a weight management survey by the Brighton and Sussex Medical School) were examined with the steering group to obtain initial reactions to different styles of presentation, colours and fonts.

A graphic design company was used to prepare the final version of the questionnaire for the full survey. They were asked to ensure that the questionnaire complied with the visual disability and reading disability guidance, that questions were not split up over two pages, that each section commenced on a new page, and that each section on new pages had the

correct column headers. The final design was in Arial, font size12, in two colours (navy and maroon), printed on cream paper and ran to 4 sides of A4 paper (see Appendix 13).

4.3 Protocol for the Survey

Patient population and inclusion criteria

The study population comprised patients attending osteopaths who were on the UK Statutory Register of Osteopaths and in private practice.

The inclusion criteria for patients were: they were currently receiving treatment at an osteopathic private practice in the UK, and had the capacity to give consent and to complete the questionnaire. The exclusion criteria were: not currently receiving osteopathic treatment, or unable to understand the questionnaire, and not having the capacity to consent. Additionally children aged less than 16 years were not eligible.

Sampling

A truly random sample of current osteopathic patients was not feasible, since patients could only be practicably recruited through osteopathic practices. This method was used in the BEAM trial, for example, and was currently being used in the large AcuBack study being conducted at University of Southampton, funded by the Arthritis Research Council (UKCRN Portfolio database, 2010). Other methods of recruitment such as public advertising would be inefficient, accessing many ineligible subjects outside the target population.

A representative systematic sample of patients was therefore sought, by selecting a random sample of osteopathic practices in the UK and asking each osteopath to invite a systematic sample of current patients to participate.

A true random sample of UK osteopaths was taken from the General Osteopathic Council (GOsC) Statutory Register of Osteopaths. The random sample of osteopaths was selected using a random number generator (www.random.org) applied to the list of contact details supplied by GOsC. Non-UK osteopaths and those with no telephone number on the record were excluded.

A sample size of 8000 patients was planned, based on the estimated compliance of 30-50% overall. To optimise diversity of practice type and location, a large sample of osteopaths was used (800, 20% of the profession), each being asked to invite 10-14 patients to participate in the survey.

The sample was created from the Statutory Register provided electronically by GOsC. The total number of osteopaths on the register was 4,039; after exclusion of those practising overseas, this decreased to 3,687, Some UK osteopaths had no telephone contact details in the file, so these were also excluded, leaving 3,132. The sample of osteopaths was stratified to ensure contributions from each country. The numbers by country were: 2,921 in England, 16 in Northern Ireland, 110 in Scotland and 85 in Wales. The sample of 800 was selected proportionately and comprised 748, 4, 28 and 20 osteopaths respectively.

Measures to optimise compliance

The quality of the study depended on a reasonably high rate of participation among the osteopaths. To raise general awareness of the study within the profession throughout the study period, articles about the study were published in The Osteopath magazine, the study was mentioned by GOsC at regional meetings, and it was supported by BOA at its annual convention in November 2009.

To promote compliance, the 800 osteopaths in the sample were twice contacted personally by letter, in order to make them aware that they would be invited to participate in the study, prior to receiving their packs of information and questionnaires, following recommendations for involvement in the literature (Boynton 2004). Advice was taken from NCOR member (SV) and from GOsC on how to most effectively word communications to osteopaths. An additional advantage of prior contact was to try to eliminate ineligible osteopaths from the sample, such as those not in current practice, or in practice within the NHS. Any osteopaths whose practices were not private or were entirely within the NHS were asked to inform the research team, as they were ineligible and they could be replaced by the next candidate on the randomly-generated list.

A further strategy to improve compliance was proposed: designing a reflective practice exercise to accompany the survey documentation, so that osteopaths could gain CPD points

by participation. This proved not to be possible within the current definitions of CPD operated by GOsC.

Recruitment protocol

To avoid selection bias, the osteopaths were asked to adhere strictly to the following recruitment protocol. The recruitment protocol was: to start on a Tuesday at 9am, and invite the first 10 consecutive eligible patients attending the practice; to add further consecutive new patients (if required) in order to achieve the target of at least 4 new patients in their sample. The instructions emphasised the importance of following the systematic recruitment protocol. Each osteopath was therefore asked to recruit a maximum of 14 patients.

Organisation

12,000 questionnaires were printed with their accompanying documentation and 800 letters to the osteopaths. The 800 osteopathic practices were sent a Survey Pack, containing a personal letter of invitation, an information sheet explaining the purpose of the study, the instructions for recruitment (Appendix 9) and 15 Participant Questionnaire Packs (PQPs, see Appendix 9): 14 for patients and one for the osteopath to read. The printing of the questionnaires was carried out by the Reprographic department of the University, and the collation and mailing by a company in Sussex (Synergy Direct Marketing Ltd).

The PQP packs (see Appendix 9) contained a letter of invitation, and a participant information sheet for adults (on blue paper). Although only adults were eligible, we provided two further Participant Information Sheets for those with lower reading ages: one for a reading age of 10-14 years (on turquoise paper) and one for a reading age of 5-9 years (peach paper). A questionnaire (yellow paper) and a stamped addressed envelope were also included. The osteopath was asked to give each patient that they recruited a PQP to take home, where they could decide whether or not to participate.

All the questionnaires were identified by a coded study number. The first four digits of the study number was a code for the osteopathic practice, and the last 5 digits were consecutive numbers. There were no hidden codes to identify patients, so no reminders could be sent to non-responders. The University of Brighton Research Ethics and Governance Committee did

not permit telephone reminders to osteopaths to encourage them to participate, for ethical reasons.

Data entry and analysis

All the completed questionnaires were returned to the Clinical Research Centre. A coding frame for analysis was designed for input of the data into an EXCEL spreadsheet. The data input software was set up, tested, and timed to estimate staffing requirements. About 5 questionnaires could be entered per hour.

The numerical / categorical data from the questionnaires were analysed using the SPSS version 16.0 statistical package. The analysis explored the associations with socio-demographic variables, and compared the expectations of sub-groups within the population.

Any comments made by patients on the questionnaire, and the small amount of data from free text questions on the questionnaires were transcribed verbatim, and subjected to a separate thematic analysis. Coding was undertaken and validated by members of the research team (VC, APM) to identify any new issues or themes which need to be explored in future surveys.

4.4 Results from the survey

Results of measures to improve compliance

The first awareness-raising letter, sent in July 2009 to the sample of 800 osteopaths to make them aware they would be invited to participate, generated responses from 22 osteopaths, of which 3 indicated they were happy to take part, 14 that they were unable to participate as they were not in current private practice, and five indicated they did not wish to take part because "money for research could be better spent elsewhere" or that they were "too busy to take part". The responses are detailed in Table 4.1 below.

Table 4.1 Responses to first letter to the random sample of 800 osteopaths

Response	Number of osteopaths	Details
Positive (N=4)	1	Asking to clarify details of selection criteria
	3	Happy to take part
Negative (N=5)	1	Do not wish to take part
	1	Money for research could be better spent elsewhere
	1	Lack of choice whether to take part
	2	Too busy
Unable to participate (N=14)	4	Work full-time in NHS
	5	Non-practising / non-practising in UK
	4	Maternity leave
	1	Sick leave

Those 14 osteopaths unable to participate for valid reasons were replaced by other osteopaths from the randomly-generated list. A second awareness-raising letter in November 2009 generated a similar number of responses.

The national survey was posted out on 18th February 2010 to 800 osteopaths. The survey generated a considerable number of queries from osteopaths (61), as well as 19 returned study packs. The communications included 26 queries from osteopaths who agreed to participate, 31 refusals to participate, and 4 who were undecided. Several osteopaths communicated their concerns at length and written responses were sent to some of these. Patients also made comments on the questionnaires. These were input for qualitative analysis.

The questionnaires were returned from 22nd February, through March and April. Receipt of questionnaires closed on 30th April, 2010 as, in the previous week, only 19 questionnaires had been received. At this date (30th April 2010), a total of **1,701** questionnaires had been received: 1 questionnaire from Northern Ireland, 107 from Scotland, 46 from Wales and the remainder (1,547) from England.

These questionnaires represented 259 different osteopaths (32.4% of the random sample). They comprised 1 from Northern Ireland, 13 from Scotland, 8 from Wales and the remainder (237) from England. It is likely that the remaining 541 osteopaths (67.6%) did not distribute their questionnaires, as we received no returns from their patients.

Osteopaths were also asked to complete a recruitment table, listing all the patients seen during the recruitment period, and return it to us. 151 of the osteopaths (58%) that participated returned this table. None were received from Northern Ireland, 9 from Scotland, 4 from Wales, and the remainder (138) from England. The information in the tables confirmed that the recruitment instructions were followed carefully and without bias by these osteopaths.

Response rates

The rate of participation of the osteopaths was 32.4%, which meant that of the 11,200 questionnaires mailed out, it is probable that no more than 3,626 (259 x 14) were distributed to patients. Of these, a total of 1701 questionnaires were received from patients, representing a patient response rate of 46.9%. This puts into perspective the rather low overall response rate of 1,701 out of 11,200 questionnaires sent out, or 15.2% overall. Table 4.2 gives more details.

Table 4.2 Response rates in the OPEn Project Survey

	England	Wales	Scotland	N Ireland	UK
OSTEOPATHS: RANDOM SAMPLE					
Packs sent for distribution	748	20	28	4	800
Practices participating*	237	8	13	1	259
Osteopaths compliance rate %	31.68	40.00	46.43	25.00	32.38
PATIENT QUESTIONNAIRES					
Sent out to osteopaths	10472	280	392	56	11200
Likely numbers distributed to patients (max)	3318	112	182	14	3626
Returned from patients	1547	46	107	1	1701
Patient response rate (min)%	46.62	41.07	58.79	7.14	46.91
Overall response rate for survey %	14.77	16.43	27.30	1.79	15.19

Quality assurance of data entry

The data input into the EXCEL file proceeded rapidly, using a total of four casual staff to assist. Five in each batch of 50 entered questionnaire scripts were checked, representing 10% of all scripts; if an error rate of 1 error in 5 scripts was found, the batch was returned for checking by the input staff. There were 122 data items per script, hence the maximum permitted error rate was 0.0016 (or 1 in 5 x 122), less than 0.2%.

Of the 1,701 questionnaires received, a total of 1,678 were entered into the database. The remaining 23 were ineligible as they were children or were (N=1) blank. After closing data entry, a few (19) further completed questionnaires were received; these were not included in the analysis.

Results from the analysis of the quantitative data

The final dataset comprising 1678 records was sent to the study statistician (MH) for analysis. Data checking showed that a further 29 questionnaires were ineligible and these were excluded: 14 who were children aged 0-15yrs and 15 respondents with age not known. There were 1649 records in the analysis.

The data were very complete with most data items having less than 1% missing values. The data items with more than 4% missing values are listed in Table 4.3, and may represent items that patients felt were not applicable to them. Apart from question E47, the statements from Section E of the questionnaire did not provide a "Not applicable" response option.

Table 4.3 Data quality: questions ranked according to % missing data above 4%

Questions showing section, question number and text	Valid	Missing	% missing
B4. Have you ever had chiropractic	1195	454	27.5
B2. When was first visit to osteopath?	1349	300	18.2
B4. Have you ever had physiotherapy	1487	162	9.8
E51. There was access for people with disability	1459	190	11.5
E22. I was provided with a gown or towel to undressed.	1472	177	10.7
E7. I signed a consent form prior to treatment being given	1504	145	8.8
E39. I was asked about the effects of previous treatment	1519	130	7.9
E9. I was given the choice of a male or female osteopath	1536	113	6.9
E21. I was given privacy to undress prior to examination and treatment.	1559	90	5.5
E25. I received vigorous osteopathy	1561	88	5.3
E40. There was communication between my osteopath and GP about my problem	1567	82	5.0
E46. I was given a time frame for improvement of my symptoms	1567	82	5.0
E44. I was given advice on how to prevent the problem happening again	1568	81	4.9
E47. My symptoms did improve within the given time frame	1576	73	4.4
E50. I was made aware that there is a complaints procedure should I need to use it	1580	69	4.2

Characteristics of respondents

Sections A and B of the questionnaire asked about patient characteristics. Table 4.4 shows the age distributions of the patients included in the analysis. They had a mean age of 54 years (SD +/- 14.9 yrs), and completed their full-time education at age 18 years (SD 3.99) with a range up to 55 years, suggesting this was a fairly educated patient population.

Table 4.4 Characteristics of patients in the analysis: age distributions

Age distributions	Mean	Median	Std. Deviation	Minimum	Maximum
Age (years)	53.96	54	14.928	16	97
Age completed education (years)	18.83	18	3.991	12	55

Table 4.5(a) shows the socio-demographic characteristics. 69.7% were female, and more than 95% were of white ethnic origin. Slightly more patients considered their area of residence was urban (50.3%) compared to rural. The great majority was employed (58.2%) or retired (31.7%), Very few (3.3%) were unemployed but 11.2% considered themselves as having a disability, and 14.8% considered their general health was fair or poor.

The health related variables (Table 4.5(b)) showed that the majority had prior experience of manual therapy i.e. osteopathy (82.1%), physiotherapy (63.1%), or chiropractic (29.8%). 17.8% were new to osteopathy. In contrast, over 52% had first visited an osteopath 5 or more years ago. 90.4% were self-funding their treatment, with 6.9% funded through insurance and just 4 patients funded by the NHS.

The majority (58.6%) presented with symptoms of moderate severity, though 15.3% considered their symptoms to be severe. For 51.1%, the duration of symptoms was "years" and for 26.9% it was days or weeks.

On the back page of the questionnaire (Section F) patients were asked whether they were satisfied with their treatment and whether they had any other expectations that had not been met. 96.5% of patients agreed or strongly agreed that they were satisfied with their treatment, and only 0.3% (5 patients) were unsatisfied. 4.5% of patients had other expectations that had not been met. There was space to write in free text, and these responses from patients were analysed separately and will be presented later in the chapter.

Table 4.5 a Characteristics of patients in the analysis: socio-demographic variables

Factor		N	%
Gender	Male	499	30.3
	Female	1149	69.7
	Missing	1	0.1
Marital status	Single	212	12.9
	Married/partner	1199	72.7
	Divorced/separated	116	7
	Widowed	114	6.9
	Missing	8	0.5
Ethnicity	White British	1499	90.9
	White Irish	26	1.6
	White Other	80	4.9
	Mixed White & Asian	4	0.2
	Mixed Other	3	0.2
	Asian or British Asian Indian	8	0.5
	Asian or British Asian Pakistani	2	0.1
	Asian or Asian British Bangladeshi	1	0.1
	Asian or Asian British Other	4	0.2
	Black or Black British Caribbean	4	0.2
	Black or Black British African	2	0.1
	Chinese	2	0.1
	Other	1	0.1
	Missing	13	0.8
Urban/rural	Rural	780	47.3
	Urban	838	50.8
	Missing	31	1.9
Employment	Employed	665	40.3
	Self-employed	295	17.9
	Unemployed	55	3.3
	Retired	523	31.7
	Other	95	5.8
	Missing	16	1
Disability	Yes	185	11.2
	No	1444	87.6
	Missing	20	1.2

Table 4.5 b Characteristics of patients in the analysis: health related variables

Factor		N	%
First visit to osteopath			
	Yes	293	17.8
	No	1354	82.1
	Missing	2	0.1
When was first visit to osteopath?			
	<1 year	163	9.9
	1-5 years	328	19.9
	>5 - 10 years	260	15.8
	>10 years	598	36.3
	Missing	300	18.2
Who pays?	NHS	4	0.2
	Private health insurance	113	6.9
	Yourself	1490	90.4
	Missing	42	2.5
Tried physiotherapy	Yes	1041	63.1
	No	446	27
	Missing	162	9.8
Tried Chiropractic	Yes	488	29.6
	No	707	42.9
	Missing	454	27.5
Current symptoms severity			
	Mild	404	24.5
	Moderate	967	58.6
	Severe	253	15.3
	Missing	25	1.5
How long symptoms experienced			
	Days	141	8.6
	Weeks	301	18.3
	Months	352	21.3
	Years	843	51.1
	Missing	12	0.7
General health	Excellent	308	18.7
	Good	1085	65.8
	Fair	225	13.6
	Poor	19	1.2
	Missing	12	0.7
I am completely satisfied with my treatment			
	Strongly agree	1130	68.5
	Agree	462	28
	Neither agree nor disagree	34	2.1
	Disagree	4	0.2
	Strongly disagree	1	0.1
	Missing	18	1.1
Do you have any other expectations of osteopathic care that have not been met?			
	Yes	75	4.5
	No	1511	91.6
	Missing	63	3.8

Patients' expectations

Section D of the questionnaire asked what the patient expected when they went to an osteopath. The responses were made using a 5-point Likert scale ranging from Strongly agree (coded as 1) to Strongly Disagree (coded as 5), with neutral coded as 3. Table 4.6 shows the patients' expectations as mean and median of the scores for the level of agreement that patients assigned to each statement. Positive agreement was defined as a median score of 2 or less, or a mean score of less than 2.5. The percentage of patients with positive expectations (agreed or strongly agreed with the statement) is also shown.

Table 4.6 Patients' expectations: mean, standard deviation, median and range of scores for expectation statements, and the percentage of patients with positive expectations

Q	Section D : what do you expect when you go to an osteopath?	N valid	Mean	Std. Dev.	Median	min	max	% positive expectation
1	Before my first treatment I expect to be given information about what will happen during treatment.	1625	**1.97**	0.87	2	1	5	**77.3%**
2	I expect to be given an explanation of what the treatment will involve before it is given	1622	**1.77**	0.721	2	1	5	**88.3%**
3	I expect to be given information about the benefits of treatment	1622	**1.85**	0.682	2	1	5	**86.8%**
4	I expect to be able to negotiate the cost of my treatment sessions if necessary	1618	**3.18**	0.982	3	1	5	**23.4%**
5	I expect to be given a choice of appointment times	1629	**1.75**	0.644	2	1	5	**92.8%**
6	I expect to be given information about the risks and side effects of treatment	1609	**1.7**	0.682	2	1	5	**90.7%**
7	I expect to sign a consent form prior to treatment	1609	**2.67**	0.959	3	1	5	**41.4%**
8	I expect the practice to display evidence of the osteopaths professional qualifications	1627	**1.62**	0.647	2	1	5	**92.7%**
9	I expect to have the choice of a male or female osteopath	1623	**2.82**	0.915	3	1	5	**30.6%**
10	I expect to see the same osteopath each time	1624	**1.71**	0.707	2	1	5	**90.5%**
11	I expect to be offered a chaperone or permitted to bring my own if I wish	1616	**2.9**	0.846	3	1	5	**28.1%**
12	I expect the waiting area to be comfortable and relaxing	1632	**2.03**	0.566	2	1	4	**84.1%**
13	I expect the clinic environment to be hygienic and professional looking	1633	**1.62**	0.544	2	1	4	**97.5%**
14	I expect the consultation to last at least thirty minutes	1634	**1.83**	0.707	2	1	5	**86.6%**
15	I expect the osteopath to only treat one patient at one time	1630	**1.36**	0.543	1	1	4	**97.9%**
16	I expect to be reassured that the information that I am asked to provide will be kept confidential	1633	**1.43**	0.593	1	1	5	**96.1%**
17	I expect the osteopath to take a detailed account of my clinical history.	1638	**1.48**	0.564	1	1	5	**97.6%**
18	I expect the osteopath to be sympathetic and caring	1631	**1.75**	0.684	2	1	5	**88.3%**
19	I expect to be involved in making decisions about my treatment	1627	**1.87**	0.737	2	1	5	**84.0%**
20	I expect the osteopath to make me feel at ease	1631	**1.62**	0.54	2	1	4	**97.5%**
21	I expect to be given privacy when undressing for diagnosis and treatment.	1621	**2.01**	0.784	2	1	4	**74.3%**
22	I expect to be provided with a gown or towel when undressed.	1621	**2.61**	0.906	3	1	5	**40.7%**
23	I expect the osteopath to identify my problem area with her/his hands.	1630	**1.82**	0.648	2	1	5	**89.5%**

24	I expect to be given a clear osteopathic diagnosis of my problem at my first appointment.	1628	**2.08**	0.799	2	1	5	**76.0%**
25	I expected the osteopathy treatment to be vigorous	1611	**2.88**	0.845	3	1	5	**29.4%**
26	I expected the osteopathy treatment to be gentle	1614	**2.81**	0.759	3	1	5	**29.7%**
27	I expect to receive electrotherapy e.g. ultrasound	1607	**3.34**	0.731	3	1	5	**7.4%**
28	I expect the osteopath to monitor my reaction to his/her treatment	1618	**1.78**	0.588	2	1	5	**92.3%**
29	I expect to be treated with respect.	1632	**1.48**	0.523	1	1	3	**98.8%**
30	I expect the osteopath to listen to me	1631	**1.49**	0.517	1	1	3	**99.1%**
31	I expect to be given a clear explanation of my problem that I understand	1630	**1.54**	0.527	2	1	4	**98.7%**
32	I expect to be told how many treatments I will need at my first appointment	1625	**2.45**	0.85	2	1	5	**54.1%**
33	I expect my osteopathic treatment to be value for money	1628	**1.72**	0.588	2	1	5	**93.5%**
34	I would forgo some luxuries to be able to afford osteopathic treatment	1619	**1.95**	0.725	2	1	5	**81.5%**
35	I expect treatment to be painless.	1621	**3.33**	0.806	3	1	5	**13.0%**
36	I expect my symptoms may get worse following treatment	1630	**2.34**	0.69	2	1	5	**64.5%**
37	I expect to be able to ask questions	1631	**1.51**	0.505	2	1	3	**99.8%**
38	I expect my questions to be answered to my satisfaction	1630	**1.65**	0.576	2	1	5	**96.2%**
39	I expect to be asked about effects of previous treatment	1613	**2**	0.692	2	1	5	**80.0%**
40	I would expect there to be communication between my osteopath and GP if necessary	1630	**2.08**	0.741	2	1	5	**78.0%**
41	I expect the osteopath to refer me elsewhere if my symptoms are not improving	1625	**1.94**	0.663	2	1	4	**83.9%**
42	I expect to be given advice about how to manage my symptoms myself	1633	**1.72**	0.543	2	1	5	**96.4%**
43	I expect to be able to phone the osteopath for advice if I needed	1633	**1.88**	0.61	2	1	5	**89.7%**
44	I expect to be given advice on how to prevent the same problem happening again	1626	**1.75**	0.567	2	1	5	**94.3%**
45	I expect to be given activities or exercises to do at home	1629	**1.99**	0.674	2	1	5	**80.8%**
46	I expect to be given a timeframe for improvement of symptoms	1616	**2.28**	0.716	2	1	5	**64.8%**
47	I expect my symptoms to improve within the given time frame	1613	**2.41**	0.731	2	1	5	**55.5%**
48	I expect to feel some pain or discomfort following treatment	1628	**2.22**	0.629	2	1	4	**72.5%**
49	I expect to be able to return to my normal activities soon after treatment	1621	**2.4**	0.719	2	1	5	**59.7%**
50	If I am not satisfied with any part of my treatment I would expect to be given information about how to make a formal complaint	1623	**2.09**	0.688	2	1	5	**79.6%**
51	I expect the practice to make provision for people with disabilities	1626	**1.96**	0.705	2	1	5	**80.1%**

Table 4.7 shows the same data ranked on the mean score for expectation. The "top 30" expectations with the strongest level of agreement are shown boxed in groups of 10 questions at the top of the table; all these expectations were highly rated, with more than 80% of patients having positive expectations. These statements are an interesting mix of service, conduct, therapeutic relationship, professional expertise, information-giving, and regulation. In toal, there were 35 (69%) of the 51 aspects of expectation that were expected by more than 75% patients.

Note that the ranking is slightly different depending on whether the percentage with positive expectations or the mean score is used. The mean was preferred for ranking as it more accurately reflects the degree of agreement; however the percentage is more readily comprehended. They are very similar: if the percentage were used for ranking instead of the mean score, the only change in the "top 10" would be that statement 42, currently ranked 15th, would be included and statement 8 would drop below 10th place.

The nine expectations at the bottom of Table 4.7, again grouped in a box, were statements that the majority of patients disagreed with. Although some may be surprising, it appeared that most patients did not expect these specific things, including a towel to cover them or to sign a consent form. However, it should be remembered that the majority of patients (82%) were not new to osteopathy, and this may reflect what patients who regularly receive osteopathic treatment expect to receive "normally".

Some additional analyses have been carried out for the 293 "new patients", those who stated this was their first visit to an osteopath. These showed that their expectations were not markedly different; somewhat more of the new patients expected to be given a towel or gown (51%) and to sign a consent form (48%), and somewhat fewer new patients expected treatment to be painless (10%). Further analyses of subsets of data will be carried out for the scientific publication.

Table 4.7 Expectations ranked highest to lowest according to the mean score

The top expectations are shown boxed in groups of ten, with graded shaded. The expectations expected by a minority of participants are shown in the box at the bottom of the table.

Q	Section D: what do you expect when you go to an osteopath?	Mean	Median	% positive expectation
15	I expect the osteopath to only treat one patient at one time	**1.36**	1	97.9%
16	I expect to be reassured that the information that I am asked to provide will be kept confidential	**1.43**	1	96.1%
17	I expect the osteopath to take a detailed account of my clinical history.	**1.48**	1	97.6%
29	I expect to be treated with respect.	**1.48**	1	98.8%
30	I expect the osteopath to listen to me	**1.49**	1	99.1%
37	I expect to be able to ask questions	**1.51**	2	99.8%
31	I expect to be given a clear explanation of my problem that I understand	**1.54**	2	98.7%
8	I expect the practice to display evidence of the osteopaths professional qualifications	**1.62**	2	92.7%
13	I expect the clinic environment to be hygienic and professional looking	**1.62**	2	97.5%
20	I expect the osteopath to make me feel at ease	**1.62**	2	97.5%
38	I expect my questions to be answered to my satisfaction	**1.65**	2	96.2%
6	I expect to be given information about the risks and side effects of treatment	**1.7**	2	90.7%
10	I expect to see the same osteopath each time	**1.71**	2	90.5%
33	I expect my osteopathic treatment to be value for money	**1.72**	2	93.5%
42	I expect to be given advice about how to manage my symptoms myself	**1.72**	2	96.4%
5	I expect to be given a choice of appointment times	**1.75**	2	92.8%
18	I expect the osteopath to be sympathetic and caring	**1.75**	2	88.3%
44	I expect to be given advice on how to prevent the same problem happening again	**1.75**	2	94.3%
2	I expect to be given an explanation of what the treatment will involve before it is given	**1.77**	2	88.3%
28	I expect the osteopath to monitor my reaction to his/her treatment	**1.78**	2	92.3%
23	I expect the osteopath to identify my problem area with her/his hands.	**1.82**	2	89.5%
14	I expect the consultation to last at least thirty minutes	**1.83**	2	86.6%
3	I expect to be given information about the benefits of treatment	**1.85**	2	86.8%
19	I expect to be involved in making decisions about my treatment	**1.87**	2	84.0%
43	I expect to be able to phone the osteopath for advice if I needed	**1.88**	2	89.7%
41	I expect the osteopath to refer me elsewhere if my symptoms are not improving	**1.94**	2	83.9%
34	I would forgo some luxuries to be able to afford osteopathic treatment	**1.95**	2	81.5%
51	I expect the practice to make provision for people with disabilities	**1.96**	2	80.1%
1	Before my first treatment I expect to be given information about what will happen during treatment.	**1.97**	2	77.3%
45	I expect to be given activities or exercises to do at home	**1.99**	2	80.8%
39	I expect to be asked about effects of previous treatment	**2**	2	80.0%
21	I expect to be given privacy when undressing for diagnosis and treatment.	**2.01**	2	74.3%
12	I expect the waiting area to be comfortable and relaxing	**2.03**	2	84.1%

24	I expect to be given a clear osteopathic diagnosis of my problem at my first appointment.	**2.08**	2	76.0%
40	I would expect there to be communication between my osteopath and GP if necessary	**2.08**	2	78.0%
50	If I am not satisfied with any part of my treatment I would expect to be given information about how to make a formal complaint	**2.09**	2	79.6%
48	I expect to feel some pain or discomfort following treatment	**2.22**	2	72.5%
46	I expect to be given a timeframe for improvement of symptoms	**2.28**	2	64.8%
36	I expect my symptoms may get worse following treatment	**2.34**	2	64.5%
49	I expect to be able to return to my normal activities soon after treatment	**2.4**	2	59.7%
47	I expect my symptoms to improve within the given time frame	**2.41**	2	55.5%
32	I expect to be told how many treatments I will need at my first appointment	**2.45**	2	54.1%
22	I expect to be provided with a gown or towel when undressed.	**2.61**	3	40.7%
7	I expect to sign a consent form prior to treatment	**2.67**	3	41.4%
26	I expected the osteopathy treatment to be gentle	**2.81**	3	29.7%
9	I expect to have the choice of a male or female osteopath	**2.82**	3	30.6%
25	I expected the osteopathy treatment to be vigorous	**2.88**	3	29.4%
11	I expect to be offered a chaperone or permitted to bring my own if I wish	**2.9**	3	28.1%
4	I expect to be able to negotiate the cost of my treatment sessions if necessary	**3.18**	3	23.4%
35	I expect treatment to be painless.	**3.33**	3	13.0%
27	I expect to receive electrotherapy e.g. ultrasound	**3.34**	3	7.4%

What actually happened?

After asking patients about their expectations, Section E of the questionnaire asked what actually happened when the patient visited the osteopath, for each of the issues mentioned in the statements in Section D. Patients could respond either that it did happen, or happened to some extent, or did not happen. Some questions allowed a "not applicable" response. Table 4.8 presents these data in terms of the percentage who considered it did not happen. This percentage is the most meaningful statistic for Section E; the mean and median are less useful as the Likert scale is un-symmetrical. There were a few questions with a substantial number of responses in the "not applicable" category.

The percentage of patients reporting that the statement did not happen, (the % did not happen in Table 4.8) ranged very widely, from 0.1% to 84.7%, and more than 25% was recorded for many statements. However, these results need to be compared back to Table 4.7, because if patients did not expect it to happen, it may be unsurprising or of little consequence that it did not happen. A measure of unmet expectations was considered a more useful measure of discordance between patient expectation and service delivery.

Table 4.8 What actually happened: showing the percentage of patients that considered it did not happen

Q	Section E : what actually happened during your visits to the osteopath?	N missing	N responses	Not applic-able	N valid *	% did not happen **
1	Before my first appointment I was given information about what would happen during treatment.	62	1587	2	1585	**20.2**
2	I was given an explanation of what the treatment involved before it was given	45	1604	0	1604	**7**
3	I was given information about the benefits of treatment	44	1605	65	1540	**9**
4	I was able to negotiate the cost of my treatment sessions	48	1601	436	1165	**83.2**
5	I was given a choice of appointment time	23	1626	1	1625	**2**
6	I was informed of the risks and side effects of the treatment	64	1585	0	1585	**25.6**
7	I signed a consent form prior to treatment being given	145	1504	0	1504	**56.8**
8	I did see evidence of the osteopaths' qualifications	43	1606	0	1606	**9.4**
9	I was given the choice of a male or female osteopath	113	1536	3	1533	**65.8**
10	I saw the same osteopath on each occasion	39	1610	130	1480	**1.9**
11	I did bring a chaperone	62	1587	728	859	**77.3**
12	The waiting area was comfortable and relaxing	22	1627	2	1625	**2.6**
13	The environment was hygienic and professional	15	1634	0	1634	**0.6**
14	The consultation lasted at least thirty minutes.	13	1636	0	1636	**1.8**
15	The osteopath did not treat other patients at the same time as me	29	1620	0	1620	**12.2**
16	The osteopath assured me that my details were kept confidential	34	1615	0	1615	**17.8**
17	The osteopath wrote down my personal case history.	23	1626	0	1626	**0.8**
18	The osteopath was sympathetic towards my problem	11	1638	0	1638	**0.4**
19	I was given the opportunity to be involved in making decisions about my treatment	31	1618	0	1618	**9.4**
20	The osteopath made me feel at ease	9	1640	0	1640	**0.3**
21	I was given privacy to undress prior to examination and treatment.	90	1559	0	1559	**12.7**
22	I was provided with a gown or towel to undressed.	177	1472	0	1472	**63.2**
23	The osteopath examined my specific problem area with her/his hands.	20	1629	0	1629	**0.8**
24	I was given a clear diagnosis of my problem at my first appointment	31	1618	0	1618	**2.7**
25	I received vigorous osteopathy	88	1561	0	1561	**30.7**
26	I received gentle osteopathy	53	1596	1	1595	**8.2**
27	I received electrotherapy treatment	57	1592	1	1591	**84.7**
28	The osteopath monitored my reactions to his/her treatment	43	1606	0	1606	**2.6**
29	I was treated with respect	13	1636	0	1636	**0.1**
30	The osteopath did listen to me	20	1629	0	1629	**0.2**
31	I was given an explanation of the cause of my problem that I was able to understand	23	1626	0	1626	**1.2**
32	I was told how many treatments I would need at my first appointment	33	1616	148	1468	**23.6**
33	My treatment was value for money	31	1618	1	1617	**1.2**
34	I am prepared to forgo some luxuries in order to have osteopathic treatment	49	1600	1	1599	**47**
35	The treatment was painless.	40	1609	0	1609	**20.7**
36	My symptoms did get worse after treatment	37	1612	1	1611	**34.3**
37	I was able to ask questions	15	1634	0	1634	**0.1**
38	My questions were answered to my satisfaction	21	1628	0	1628	**0.1**
39	I was asked about the effects of previous treatment	130	1519	1	1518	**22.4**
40	There was communication between my osteopath and GP about my problem	82	1567	782	785	**72.6**

41	The osteopath was able to refer me elsewhere when my symptoms did not improve	55	1594	1082	512	**71.3**
42	I was given advice about how to manage the symptoms myself	36	1613	1	1612	**6.1**
43	I was given the opportunity to receive advice from the osteopath over the telephone	30	1619	383	1236	**23**
44	I was given advice on how to prevent the problem happening again	81	1568	1	1567	**13.9**
45	I was given activities and exercises to do at home	48	1601	1	1600	**17.4**
46	I was given a time frame for improvement of my symptoms	82	1567	2	1565	**24.9**
47	My symptoms did improve within the given time frame	73	1576	512	1064	**7.9**
48	I did feel some pain or discomfort following treatment	45	1604	0	1604	**22.1**
49	I was able to return to my normal activities soon after treatment	58	1591	2	1589	**5.3**
50	I was made aware that there is a complaints procedure should I need to use it	69	1580	2	1578	**68**
51	There was access for people with disability	190	1459	1	1458	**26.5**

* Valid responses were coded 1 to 3 meaning: did happen, happened to some extent and did not happen

** "Did not happen" used the total valid responses as the denominator

Unmet expectations

The meaning of "unmet expectation" needed to be defined clearly. The definition used was that, for a specific aspect of expectation, (i) the individual had positive expectation about it and (ii) that the aspect did not happen. A full definition is given in Appendix 10. The extent of unmet expectation was therefore computed as the percentage of people with positive expectations who considered "it did not happen" and is shown as "% unmet expectations" in Table 4.9. The statements are ranked from highest to lowest percentages of unmet expectation. For about half the statements in the table, more than 10% of all patients had positive expectations which were unmet.

Note that care is needed in the interpretation of the data in Table 4.9. For example, some expectation statements that are high in the list in Table 4.9 are those where the majority of respondents did not expect it to happen (from Table 4.7), and therefore it could be regarded as concordance that it did not happen. Those with fewer than 30% respondents expecting it are coloured in blue and italicised.

For this analysis, a subgroup analysis was conducted for the new patients only, as it was suspected that the extent of unmet expectation might be somewhat different from that of returning patients, some of whom had many years of familiarity with osteopathic care. These

results are shown in the right hand column of Table 4.9. What was surprising was that the unmet expectations of new patients was so similar to that of the majority, on the whole. There were some exceptions, with marked differences indicated with "*", in aspects related to the first visit and to anticipation of pain.

Some of the questions in the questionnaire related to expectation of pain, suffering or financial sacrifice. These questions should perhaps be categorised separately, as clearly it is probably preferable if these things do not happen even if expectation is positive. In addition, where patients responded that "I am prepared to forgo some luxuries in order to have osteopathic treatment" did not happen, this may reflect their financial situation rather than feelings about osteopathy. Interestingly, about 30% of patients considered that they had forgone luxuries to have treatment.

Table 4.9 The percentage of patients expecting each item that had unmet expectations, ordered from highest to lowest unmet expectation, for all respondents and for new patients only

Shading *indicates a minority of participants expected this aspect;*
""* *indicates a marked difference between new patients and participants overall.*

Q	Section E : what actually happened during your visits to the osteopath?	% with positive expectation	% with unmet expectations	% with unmet expectations - <u>new patients only</u>
50	I was made aware that there is a complaints procedure should I need to use it	**79.6%**	65.63	70.8
4	*I was able to negotiate the cost of my treatment sessions*	***23.4%***	*53.91*	*69.14 **
22	I was provided with a gown or towel to undress	**40.7%**	44.33	48.51
34	I am prepared to forgo some luxuries in order to have osteopathic treatment	**81.5%**	40.93	39.07
27	*I received electrotherapy treatment*	***7.4%***	*39.66*	*53.33 **
9	I was given the choice of a male or female osteopath	**30.6%**	37.1	49.42 *
40	There was communication between my osteopath and GP about my problem	**78.0%**	33.91	34.68
11	*I did bring a chaperone*	***28.1%***	*33.26*	*35.87*
7	I signed a consent form prior to treatment being given	**41.4%**	28.82	34.07

36	My symptoms did get worse after treatment	**64.5%**	23.24	27.42
6	I was informed of the risks and side effects of the treatment	**90.7%**	22.98	23.85
51	There was access for people with disability	**80.1%**	22.46	25.48
41	The osteopath was able to refer me elsewhere when my symptoms did not improve	**83.9%**	21.92	20.75
39	I was asked about the effects of previous treatment	**80.0%**	17.23	36.26 *
16	The osteopath assured me that my details were kept confidential	**96.1%**	17.02	21.09
46	I was given a time frame for improvement of my symptoms	**64.8%**	16.73	20.83
43	I was given the opportunity to receive advice from the osteopath over the telephone	**89.7%**	15.78	15.12
1	Before my first appointment I was given information about what would happen during treatment.	**77.3%**	14.8	25.23 *
32	I was told how many treatments I would need at my first appointment	**54.1%**	13.75	17.47
48	I did feel some pain or discomfort following treatment	**72.5%**	13.66	17.43
44	I was given advice on how to prevent the problem happening again	**94.3%**	12.5	20.9 *
15	The osteopath did not treat other patients at the same time as me	**97.9%**	11.96	13.83
45	I was given activities and exercises to do at home	**80.8%**	11.92	15.06 *
21	I was given privacy to undress prior to examination and treatment.	**74.3%**	8.87	11.11
8	I did see evidence of the osteopaths' qualifications	**92.7%**	7.91	14.74*
3	I was given information about the benefits of treatment	**86.8%**	7.88	12.79 *
25	*I received vigorous osteopathy*	***29.4%***	*7.58*	*13.41 **
19	I was given the opportunity to be involved in making decisions about my treatment	**84.0%**	7.55	11.97 *
42	I was given advice about how to manage the symptoms myself	**96.4%**	5.81	9.74
2	I was given an explanation of what the treatment involved before it was given	**88.3%**	5.44	6.84
47	My symptoms did improve within the given time frame	**55.5%**	4.82	4.32
35	*The treatment was painless.*	***13.0%***	*4.31*	*12.9 **
49	I was able to return to my normal activities soon after treatment	**59.7%**	3.28	2.71

12	The waiting area was comfortable and relaxing	**84.1%**	2.42	3.38
28	The osteopath monitored my reactions to his/her treatment	**92.3%**	2.05	3.88
24	I was given a clear diagnosis of my problem at my first appointment	**76.0%**	1.96	1.89
26	*I received gentle osteopathy*	***29.7%***	*1.69*	*3.61*
5	I was given a choice of appointment time	**92.8%**	1.6	3.37
10	I saw the same osteopath on each occasion	**90.5%**	1.18	1.92
31	I was given an explanation of the cause of my problem that I was able to understand	**98.7%**	1	0.35
33	My treatment was value for money	**93.5%**	1	1.5
14	The consultation lasted at least thirty minutes.	**86.6%**	0.85	0.81
17	The osteopath wrote down my personal case history.	**97.6%**	0.63	0.71
	The osteopath examined my specific problem area with her/his hands.	**89.5%**	0.62	0.78
13	The environment was hygienic and professional	**97.5%**	0.5	1.08
20	The osteopath made me feel at ease	**97.5%**	0.32	0.71
18	The osteopath was sympathetic towards my problem	**88.3%**	0.28	0.82
30	The osteopath did listen to me	**99.1%**	0.19	0.37
38	My questions were answered to my satisfaction	**96.2%**	0.13	0.37
29	I was treated with respect	**98.8%**	0.06	0
37	I was able to ask questions	**99.8%**	0.06	0

Results from the open questions about expectations

In Section F, the last page of the questionnaire, the respondents were asked to list "your three most important expectations of your osteopathic care". A total of 1,657 (98%) of the 1,678 participants responded to this question. These free text data were analysed by the qualitative expert in the team (VC). Simple content analysis, allowing for repetition and semantic equivalence yielded twenty-five key expectations. These are listed in Table 4.10 in descending order of inclusion in each participant's top three.

The important expectations revealed by these responses were consistent with those revealed in the qualitative section of the questionaire; there were two new issues which were not asked

about in the body of the questionnaire: being free from the need for medication or medical intervention (no. 22) and the osteopath taking a holistic approach to care (no.24) . Although not mentioned frequently, these are worthy of consideration for future questionnaires.

The remaining questons in Section F generated few free text responses These did not add to the data already collected, apart from mention of unexpected treatment modalities such as acupuncture (N=33), cranial osteopathy (20) and ultrasound (8). 77 patients stated that they had unmet expectations; their comments were consistent with the findings in the Tables above.

Table 4.10 Summary of the most important expectations from the open question, ordered according to frequency of mention by questionnaire respondents *(n=1657)*

1.	There will be an immediate, perceptible improvement in symptoms	47.1%
2.	The Osteopath will be caring and listen to what I have to say	21.6%
3.	I will be able to return to my normal activities/have an improved quality of life	19.3%
4.	I will be given advice on how to manage my problem and prevent recurrence/worsening of symptoms	18.7%
5.	I will be given a clear and honest explanation of my problem and what can be achieved	17.9%
6.	My problem will eventually resolve completely as a result of the treatment	16.8%
7.	I will receive appropriate, effective treatment	13.1%
8.	The Osteopath will quickly identify the nature of my problem	11.5%
9.	The cost of treatment will be reasonable and value for money	10.0%
10.	The Osteopath will behave in a professional and confident manner	7.9%
11.	The Osteopath will be readily available as needed, and flexible about appointment times	7.7%
12.	I will be treated with respect and confidentiality	7.7%
13.	I will feel safe, and able to trust the Osteopath	6.4%
14.	I will receive hands-on, gentle/pain-free treatment	5.7%
15.	There will be a friendly, relaxed atmosphere in the practice	5.2%
16.	I will be encouraged to be actively involved in discussion and decision-making about my treatment	5.0%
17.	There will be a clear treatment plan and timescale set out	4.2%
18.	The practice environment will be clean and hygienic	3.9%
19.	The Osteopath will have good knowledge of my particular problem	3.5%
20.	I will be able to receive ongoing monitoring of my problem over time	3.3%
21.	The Osteopath will take a detailed history and carry out a thorough examination prior to treatment	2.8%
22.	I will be freed from the need for medication or other medical intervention	1.3%
23.	The treatment will be vigorous/painful	0.9%
24.	The Osteopath will take a holistic approach to my care	0.9%
25.	I will be referred to other sources of treatment or help if this is necessary	0.8%

4.5 Discussion of results from the survey

The survey phase within this project has permitted a robust statistical evaluation of the expectations of osteopathic patients in private practice. Over 96% of respondents were satisfied or very satisfied with their osteopathic care, providing a very positive message for the profession. Only 0.3% were unsatisfied.

Patients' expectations of osteopathic care

The majority of respondents had positive expectations (agreed with) about most of the 51 expectation statements derived from the focus groups and interviews, and the literature from the wider healthcare arena. There were 36 (71%) of the 51 statements with more than 75% of respondents in agreement. These 36 statements were termed highly positive expectations, and of these there were 5 statements that respondents strongly agreed that they expected, with more than 96% in positive agreement and a median score of 1 (strongly agree):

- for the osteopath to only treat one patient at a time;
- to be reassured that the information they were asked to provide would be kept confidential;
- for the osteopath to take a detailed account of their clinical history;
- to be treated with respect;
- for the osteopath to listen to them.

Fewer than 50% of respondents agreed with 9 of the statements, which included expecting:

- To be provided with a towel or gown when undressed;
- To sign a consent form prior to treatment;
- Treatment to be gentle;
- A choice of male or female osteopath;
- To be offered a chaperone.

and a substantial majority disagreed with these three statements:

- They expected to be able to negotiate the cost of treatment;
- They expected treatment to be painless;

- They expected to receive electrotherapy.

Patients expectations were also evaluated in a second way: they were asked to name their "most important expectations", in their own words. One topic stood out, being mentioned by almost half of respondents, with five further topics mentioned by more than 15% respondents. In order of frequency of mention, their six most important expectations were:

- To have an immediate, perceptible improvement in symptoms;
- The osteopath to be caring and listen to what they had to say;
- To be able to return to their normal activities/have an improved quality of life ;
- To be given advice on how to manage their problem and prevent recurrence/ worsening of symptoms;
- To be given a clear and honest explanation of their problem and what can be achieved;
- Their problem to eventually resolve completely as a result of the treatment;
- To receive appropriate, effective treatment.

The differences between the "top expectations" emerging from the open question in Section F and the statements in Section D may stem from the fact that agreement is more concerned with a patient's feelings and importance is concerned with their priorities. Both are useful guides to patient-centred expectation and section F may be a source of additional questions for future questionnaires. The important expectations, in contrast with the strongly positive expectations, were more concerned with effective treatment. Clearly effective treatment must not be forgotten as an objective of consulting with an osteopath! The concordance between the two types of question provides triangulation of the results, especially in respect of listening, information-giving, and explanation of the problem.

Unmet expectations of osteopathic care

The degree to which patients' expectations were met was measured. There was much good news for the profession in these results, as most of the 51 expectations were met well for the patients within the survey, with 28 (55% of expectations) being met for more than 90% respondents. Table 4.11 shows the degree to which the "top 10 expectations" were met – the

percentage of respondents with unmet expectations ranging from 17% (confidentiality) to 0.06% (being treated with respect, and being able to ask questions).

Table 4.11 Unmet expectations for the top 10 expectations

Q	Section D : what do you expect when you go to an osteopath?	% expected	% unmet expectations
15	I expect the osteopath to only treat one patient at one time	97.9%	11.96
16	I expect to be reassured that the information that I am asked to provide will be kept confidential	96.1%	17.02
17	I expect the osteopath to take a detailed account of my clinical history.	97.6%	0.63
29	I expect to be treated with respect.	98.8%	0.06
30	I expect the osteopath to listen to me	99.1%	0.19
37	I expect to be able to ask questions	99.8%	0.06
31	I expect to be given a clear explanation of my problem that I understand	98.7%	1
8	I expect the practice to display evidence of the osteopaths professional qualifications	92.7%	7.91
13	I expect the clinic environment to be hygienic and professional looking	97.5%	0.5
20	I expect the osteopath to make me feel at ease	97.5%	0.32

Of the 36 highly positive expectations, there was one which was met particularly poorly, with only one-third of respondents considering it had happened:

- To be made aware that there was a complaints procedure should they need to use it.

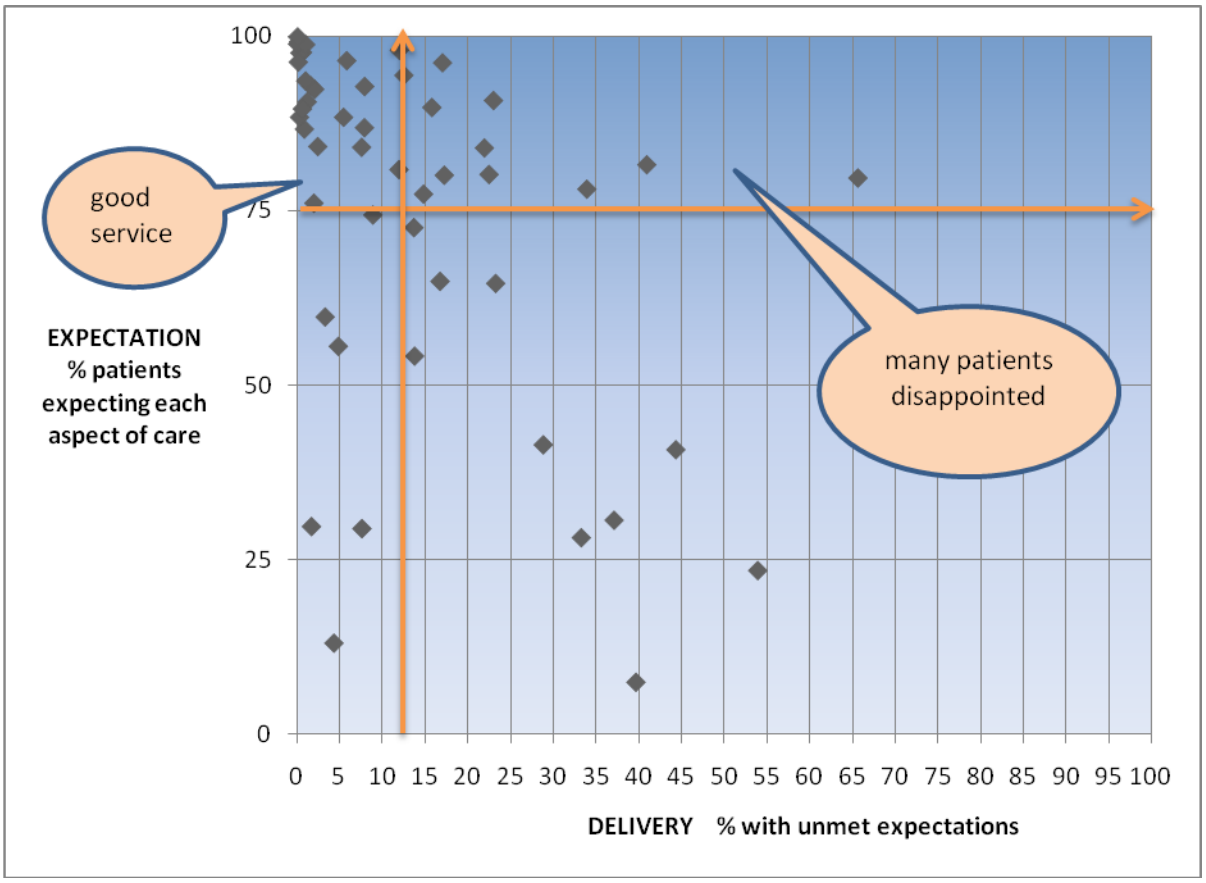
There were seven other highly positive expectations that were met only moderately well (with between 15-39% of respondents considering them unmet):

- There being communication between their osteopath and GP about their problem;
- To be informed of the risks and side effects of treatment;
- There being access for people with disabilities;
- The osteopath to be able to refer them elsewhere when their symptoms did not improve;
- To be asked about the effects of previous treatment;
- The osteopath to assure them that their details were kept confidential;
- To be given the opportunity to receive advice from the osteopath over the telephone.

In terms of service delivery and customer care, failure to meet expectations for more than 10% of patients could be considered rather poor. This applied to 23 expectations in total, and included perceptions of not receiving explicit information on qualifications, the complaints procedure, and disability provision; explicit reassurance about confidentiality; information before first attending about the treatment and process of care and about the option of bringing a chaperone; and explicit information during consultation about risks, benefits and side-effects where appropriate.

The relationship of expectation and delivery is shown in Figure 4.1, using a threshold of 12.5% for service delivery, based on theoretical considerations (see Appendix 12). The overall message from Figure 4.1 was that osteopathic care was delivering a good service with few unmet expectations. However there were 11 aspects of care causing disappointment to substantial numbers of patients.

Figure 4.1 Expectation against perceived delivery for each aspect of care



At least half of the expectations were well met, with fewer than 10% of unmet positive expectations. The following were the best met, with less than 1% of respondents having unmet positive expectations:

- To be treated with respect;
- To be able to ask questions;
- For questions to be answered to their satisfaction;
- The osteopath to listen to them;
- The osteopath to be sympathetic towards their problem;
- The osteopath to make them feel at ease;
- The environment to be hygienic and professional;
- The osteopath to examine their specific problem area with her/his hands;
- The osteopath to write down their personal case history;
- The consultation to last at least thirty minutes;
- To be given an explanation of the cause of their problem that they were able to understand;
- Their treatment to be value for money.

Implications for osteopathic practice

All the results in this chapter can be considered to have implications for the osteopathic profession. It is clear that patients have expectations about many aspects of osteopathic practice. 48 out of the 51 statements about expectation were positively endorsed by the patients within the survey, and the results as a whole define more clearly for the profession what patients expect when they seek osteopathic care.

Within this discussion of the results of the survey (section 4.5), the five most strongly held expectations and the six most important expectations are highly relevance to the osteopathic profession. The regulator needs to ensure these are part of the standards; the education providers need to ensure they are part of training; and practices need to ensure these aspects of care or service are delivered.

The nine expectations which were not well met signpost the priorities for improving care or managing expectation better. As emphasised by the literature review, gaps between expectations and delivery of care have a negative effect on outcomes of care.

The top expectation that the osteopath should treat only one patient at a time perhaps reflects expectations of value for money. Busy practices having several patient cubicles operating in parallel, and even osteopaths answering the telephone to other patients during a treatment session may contravene the patient's expectation of personal care.

17% of respondents considered that they were not reassured about of confidentiality. This does not mean that confidentiality was breached, but that reassurance was not given. However, this appears to be a prime concern for patients.

It would be prudent for the profession not only to prioritise the very poorly met expectations, but also to prioritise (i) expectations that can be met easily, where simple changes in practice could diminish the gap between expectation and delivery, without compromise to the healing environment or therapeutic relationship; (ii) all expectations that were unmet for more than 10% of respondents, and (iii) expectations that seem basic aspects of professional practice such as routinely offering towels or gowns for modesty, and hygiene.

Managing expectations may also be important for the profession. For example, patients can be given information and explanation about the need to undress and cost structures before attending, so that they know what to expect. If there are preferences and choices available in the gender of the osteopath or the type of osteopathy (or other therapies) used by the osteopath, these could also be explained. If the osteopath is so busy within the practice, or in demand on the telephone, that personal levels of care are compromised, then the patient needs to be forewarned that they will not have exclusive attention from the osteopath. There may be a need to manage expectations during the consultation, about anticipated pain levels during and after treatment, and about the certainty or uncertainty of the diagnosis and prognosis, and how this may change over time. The expectations of an "immediate, perceptible improvement in symptoms" and "my problem resolving completely as a result of treatment" may need to be managed, as the osteopath thinks fit in relation to the presenting condition.

There were two issues which featured high in the list of unmet expectation, which may need further investigation in order for the profession to know how to address them. One was about communication with the patient's GP. It appears to be high in patient priorities and poorly met by osteopaths. Similarly, signing a consent form prior to treatment. Although many patients did not expect this, a substantial proportion did, and their expectation was often unmet.

Limitations of the data

The survey findings were consistent with those in the survey and the literature review, in terms of the aspects of expectation within osteopathy. However, the ranking of those aspects of expectation and the extent to which expectations were met is likely to vary between different populations, and between types of service.

The population within this survey were rather homogeneous with respect to educational level, ethnicity (white) and employment status. Homogeneity increases the robustness of the findings but limits their generalisability to non-white or socially less advantaged groups. The results are specific to the culture of the patient population, which was very much dominated by white ethnic groups, and those with the ability to pay for private care. Culture is likely to have a strong effect in this type of study. As Malcolm Gladwell observed ("Outliers"; Little, Brown and Company, UK 2000),

"Cultural legacies are powerful forces. They have deep roots and long lives. They persist, generation after generation, virtually intact, even as the social and demographic conditions that spawned them have vanished, and they play such a role in directing attitudes and behaviour that we cannot make sense of our world without them."

The response rate was limited by poor compliance of the osteopaths (32.4%), so that despite the reasonable response rate of 46.9% from patients, the overall response rate was 15.2%. A low response rate can introduce considerable bias. The most probable bias may be towards osteopathic practices which are more "research-friendly": it is possible that these practices may differ in the quality of their service. We were aware that in other surveys in professions such as acupuncture, a compliance rate of 30% of the profession was typical. The response

rate may not be atypical for this kind of research arena, especially when there are no incentives such as prizes for participants (which were not allowed by our ethical committee).

Selection bias in patient recruitment by osteopaths was monitored and found to be minimal: the participating osteopaths completed recruitment forms, which showed that they carefully followed the instructions for recruiting consecutive eligible patients, so the potential selection bias is probably slight. The mean age of completing full-time education of 18 years may suggest a respondent bias in favour of more educated patients.

The questionnaire performed well, in that patient response rate was good, and a high proportion of respondents completed all questions, including the free text question which generated Table 4.11. A few questions/ statement generated more than 4% missing values, and could be candidates for revision. The qualitative question identified some further potential candidate statements. The structure of the questionnaire permitted the research question to be answered precisely (what are patients expectations, and to what extent are they met?). The wording of the statements "I expect…" allowed respondents to use their own interpretation of expectation, rather than the researchers imposing a layer of interpretation through the use of alternative wordings as was done in some previous instruments described in the literature review.

The survey population represented osteopathic **private** practice England, Wales, Scotland and Northern Ireland. Caution needs to be exercised in extending the implications for practice to other countries or to other types of osteopathic service, such as the NHS.

Further research

There is a need for further research to:

- utilise the existing dataset further, exploring the influence of variables such as age and gender, it represents a rich resource for the profession;
- modify the questionnaire a little in the light of the experience gained in the project, as a resource for further surveys;
- conduct further surveys to confirm the findings of this study; in other osteopathic settings such as Osteopathic Educational Institutions and the NHS services; in specific

areas serving different social groups; at intervals in order to explore changes over time.

Chapter 5 Discussion

Summary of chapter 5

All three phases of the project contributed to meeting the brief and answering the research questions for patients attending osteopathic practices in the UK.

Firstly, the aspects of osteopathic care about which osteopathic patients have expectations were identified within the literature review (phase 1) in outline, and by the focus groups and interviews with osteopathic patients (phase 2) in greater depth. In addition, an understanding of the relationship between the components of expectation was gained from all three phases and a model emerged which provided insight on patients' perceptions of care. The way that expectations may vary according to patients' characteristics was described by the literature review, based on studies across a range of types of healthcare; some insight was also provided by the focus groups and interview in phase 2.

Secondly, the survey (phase 3) was then used to quantify - for private osteopathic practice - the relative importance of each of the 51 identified aspects of expectation, and to elicit further expectations for use in future research. The extent to which private osteopathic patients perceive that their expectations were met or unmet was evaluated by the survey questionnaire in phase 3. The survey also suggested showed that the expectations of new patients were very similar to those of returning patients with prior experience of osteopathy. However, the sample of osteopathic patients that responded to the survey was rather homogeneous, and the numbers within minority groups was too small to permit sub-group analysis by ethnic group or educational level.

The consistency of the findings across the three phases of the study lends weight to the findings, which are considered to represent robust preliminary evidence about the expectations of osteopathic patients.

The most important expectations and the worst met positive expectations that were identified in the survey will enable the profession to set priorities for improving care within private

practices: these will apply to the regulator in respect of the standards, to educators in respect of training, and to practices in respect of service delivery. As emphasised by the literature review, gaps between expectations and delivery of care have a negative effect on outcomes of care.

For the Regulator, the findings highlighted the areas where targeted guidance to the profession on practice issues might be required; and obstacles to disseminating the findings of the study to the profession. The priority areas are outlined below under implications for the profession. Secondly, the expectations of patients which were not covered by the Osteopathic Code of Practice were highlighted. When next reviewing the Code, the GOsC may need to consider both the patient-centred model of expectations and those specific expectations which are not included within the current Code of Practice. In particular, there were several statements about aspects of the therapeutic process which appear to be without corresponding clauses in the Code of Practice; this seemed surprising as the results suggested these issues were important to patients.

For the profession, the implications related to improving the delivery of care; the priorities are underlined in the list below. Firstly, patients expect their osteopath to support their ***individual agency****:*

- *To help the patient to gain control over their problem; they may already know a lot about their problem, may well have consulted doctors and other manual therapists previously, including osteopaths, and may have preferences about the sort of osteopathy they want to receive;*
- *To support a patient's need to know about their problem, by providing clear information and advice about the problem and on how to prevent it recurring;*
- *To empower the patient to take control themselves, where possible, for example utilising home exercises or advice;*
- *To appreciate the vulnerability imposed by suffering pain or by financial sacrifice if that is necessary;*

Patients expect their osteopath to demonstrate evidence of ***professional expertise****:*

- *To provide a good explanation of the causes of the patient's problem at the first visit, and to provide relief of symptoms within a reasonable timeframe;*

- *To observe clear boundaries especially in respect of the undressing and the intimacy of touch which may be required. The intimacy of contact during osteopathic treatment places a huge responsibility on the practitioner for maintaining a professional manner; patients held up GPs as the benchmark in this respect;*
- *To inform patients about the need and reasons for undressing, prior to their first visit;*
- *To have a broad knowledge of other types of health care and to refer to other healthcare professionals if appropriate (this is quite challenging especially for newly-fledged practices as local links to other health care professionals take time to forge);*
- *To enhance and perhaps make more explicit the process of effective triage at first appointment, with referral if required.*

Patients expect their osteopathic practice to offer a quality ***customer experience****:*

- *To provide details about the nature of the osteopathic intervention at an early stage in the pathway;*
- *To ensure that the way the practice is organised, the training of staff and osteopath(s) in customer care, the atmosphere within the practice, and the dialogue around payment and frequency of follow-up are sensitive to patients; if these expectations are met, then this will contribute to both satisfaction and clinical outcomes;*
- *The osteopath should treat only one patient at a time (note that this was the highest of all patients' expectations); if this level of personal service is not provided, for example when several patient cubicles are operating in parallel, or the osteopath answers the telephone to other patients during a treatment session, patients should be informed prior to attendance;*
- *Ensuring that patient confidentiality is respected by all staff within the practice, including receptionists;*
- *Providing information about how to make a formal complaint (note that this was the worst met of all expectations).*

Patients expect their osteopath to provide a patient-centred ***therapeutic process****:*

- *Communicating realistic expectations about the impact of treatment on their symptoms;*
- *Providing accurate information about risks, and to advise on safe treatment options;*

- *To take safe decisions for patients who want to trust the osteopath to make all decisions about their treatment;*
- *Informing patients about what to expect in relation to treatment and outcomes including side-effects; it is helpful to provide pre- attendance information about the nature of treatment and the likely after-effects, and reassurance about the level of pain that might be experienced during treatment.*

Patients expect and value their ***interpersonal relationship*** *with their osteopath and expect the osteopath to:*

- *Explore the patient's preferences for and attitudes to involvement in their care;*
- *Nurture a professional inter-personal relationships with patients;*
- *Provide two types of information to meet patients' concerns – about risks and side effects of treatment and reassurance of confidentiality; osteopaths need to provide these more consistently and as a matter of priority;*
- *Make the consent process more explicit e.g. using a consent form or obtaining verbal agreement explicitly after explanation and dialogue with the patient.*

For ***professional training and for CPD, the main*** *implications involved the need for training and support beyond the scope of osteopathic technique and professional practice, and particularly in the following areas:*

- *Interpersonal skills, such as communication skills and empathy;*
- *Personal development and psychological health;*
- *Evidence and judgement of clinical risks;*
- *Professional conduct and boundaries in respect of touch and clinical examination; perhaps incorporating aspects of medical clinical training, to develop a "GP-like" approach to touch;*
- *A broad knowledge of other types of health care and how to forge links with other healthcare professionals for referral purposes.*

The main findings of the study were that patients' expectations of osteopathic care are complex and concern over 50 aspects of care; in private practices in the UK, most of the expectations of patients were met and a very high proportion of patients were satisfied with

their care. There were a few expectations which were found to unmet in private practice for more than 10% of patients; identification of such gaps in the quality of the service will enable the profession to improve the quality of osteopathic services for the future.

5.1 Introduction

This chapter discusses the findings of the project as a whole, comparing the results found in the three phases of the study. The specific phases of the study were discussed in detail within the previous chapters. This chapter examines whether the research questions have been answered, the limitations of the evidence to date, and the implications for the Regulator, for osteopaths, for education and training, and for patients.

The research questions posed initially were:

1. What are the specific aspects of osteopathic practice about which patients have expectations?
2. To what extent do patients perceive that their expectations are met or unmet?
3. How do expectations vary according to the patients' characteristics and background, including minority groups?

The project as a whole was challenging to complete within the 12 months timescale. The scientific protocol was rigorous; the research team at the University of Brighton comprised specialists in the various methodologies within the project, including questionnaire design and analysis, and qualitative methods.

5.2 The specific aspects of osteopathic practice about which patients have expectations

The specific aspects of osteopathic practice about which patients have expectations were identified in each of the three phases of the study. The literature review identified many aspects of expectation related to other areas of healthcare. The osteopathic literature was scant, but suggested some expectations of osteopathic patients within five areas of the service:

- Clinic Environment (healing, accessible, flexibility of appointments);
- Professionalism (continuity of care, technical skill);
- Treatment (effective manual treatment, physical realignment of the spine, advice and prescription of exercise, an holistic approach);

- Relationship (interpersonal skills; offers hope, communication, respect and trust; shared decision-making tailored to the individual);
- Outcome (reduction of pain, improved quality of life).

All this evidence was preliminary, being base on small studies and required testing in further research. The actual relevance of these and the other factors that were identified within the literature review was tested within the subsequent phases of the study. All the identified factors became candidate topics for use in the Focus Group.

The qualitative interviews with osteopathic patients in Phase 2 identified many aspects of expectation of osteopathic patients. These aspects, together with those from the literature, became candidate questions for the questionnaire.

In addition, the literature review and the qualitative phase were used to create a model of the relationship between the numerous aspects of patients' expectations. The model that emerged from the literature review was based on health care in general, and had three main components: the patient characteristics, the healthcare context, and the therapeutic encounter. An osteopathy-specific model of expectations was developed independently from the discussions with osteopathic patients in the focus groups and interviews. The osteopathic model was consistent with and expanded on the general model from the literature review, and aids understanding of osteopathic patients' expectations in the area of the context and the therapeutic encounter.

Table 5.1 Comparison of the components of the thematic models of patients' expectations

Model from Literature Review	Model from focus groups and interviews
Patient characteristics	*(specific to population studied)*
Healthcare context	Customer experience
Therapeutic encounter -technical	Professional expertise; Therapeutic process.
Therapeutic encounter- personal	Individual agency; Interpersonal relationship.

A new osteopathy-specific questionnaire was developed incorporating the aspects of expectation identified in the first two phases of the project. The literature review had established that there were no standardised or validated published questionnaire tools for measuring expectations. The survey phase of the study was used to test the relative importance of fifty-one aspects of expectation, within patients attending private osteopathic practices. The survey allowed the fifty-one different aspects of expectation to be ranked in importance according to the degree to which patients agreed or disagreed that they expected them.

5.3 The extent to which patients perceive their expectations are met or unmet

The scant osteopathic literature provided weak evidence suggesting that patient satisfaction was high and expectations largely met in osteopathy. There was some suggestion of a lack of preparation for the need to undress; and perhaps clearer goals needing to be set for treatment outcomes.

The focus groups and interviews with UK osteopathic patients in private, OEI, and NHS practices, reinforced the overall message of happy clients who valued the service provided. Few unmet expectations emerged; these related to insufficient preparation and dialogue about the (forceful) nature of the intervention or inadequate pre-treatment information so that the experience of osteopathic "crunching" and the level of side-effects after treatment came as a surprise. Some were unhappy about having to undress, or had not realised that it would be required. There was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this was an area of concern for patients where expectations may possibly be unmet. Some participants described previous experiences that had not met their expectations in terms of the environment (e.g. lots of cuddly toys in the room) or discomfort about the relationship/ boundaries.

The survey was the main source of evidence about unmet expectations. Note that this was limited to private practices. The survey participants were asked, for each of the fifty one aspects of expectation, whether it happened when they visited the osteopath. Participants were forth-right about which of their expectations were not met when they visited the osteopath. The proportion of patients with unmet positive expectations ranged widely, from

almost zero at best, to 66% at worst, the latter relating to patients' expectation that they be made aware that there was a complaints should they need to use it. Most aspects of expectation were being met, but there were a few aspects of the osteopathic service which were not meeting patients' expectations, and could be improved, as will be detailed in the next section.

5.4 Interpreting the findings of the study

In the following sections, the findings from all three phases of the study will be drawn together. The findings will be presented within the framework of the five-component model of expectations of osteopathic care that was derived in the qualitative phase (phase 2). In each of the following sections, the evidence about the expectations of osteopathic patients from the initial phases of the study are summarised first, then the findings from the survey are presented in tabular form (in Tables 5.4 through 5.8).

In order to aid in policy-making and allow judgements to be made, the precise statistics from the survey, as presented in the previous chapter, have been converted into broad levels or bands, as shown in the table below (Table 5.2). The upper and lower limits of the bands for expectation were based on both statistical considerations; those for unmet expectation were based on quality assurance targets.

Table 5.2 Definitions of levels of positive expectations and unmet expectations

Code	Meaning	Level of positive expectation	Level of unmet expectation
		% of patients with positive expectations	% patients with unmet, positive expectations
0	VERY LOW	0-24% (very few)	0 - 4% (almost none)
1	LOW	25-49% (some)	5 - 9% (few)
2	MODERATE	50-74% (many)	10 - 14 % (more than desirable)
3	HIGH	75-89% (most)	15 - 39% (too many)
4	VERY HIGH	90-100% (almost all)	40-100% (unacceptable)

In addition, in Tables 5.4- 5.8 below, various symbols are used (see Table 5.3): a book symbol 🕮 denotes evidence from the literature. A pen symbol 🖉 and handwriting font denotes expectations elicited in free text from respondents as their most important expectations. The most highly positive expectations and the worst met expectations are denoted using the symbols ❄ and ■ respectively.

Table 5.3 Key to symbols used in the tables

🖉	*"Important" expectations provided in free text by respondents.*
🕮	Expectations supported by evidence from the literature.
❄	Top expectations (median score of 1= strongly agree), or over 15% respondents mentioned as important in the free text question, as listed in chapter 4.
■	The worst met highly positive expectations (expectation was high or very high, and unmet expectation was high or very high, as listed in chapter 4).

The final column in each table below shows the clauses within the GOsC Code of Practice (2005) that relate to the specific aspect of expectation. There appeared to be a number of expectation statements that not covered by the Code of Practice, shown by an "n/a". *(Note: The Clause numbers and the missing ones should be reviewed by GOsC for accuracy, as the researchers are not experts on the Code, before the implications are considered by them).*

5.5 Expectations of individual agency

Individual agency was the first theme of the qualitative model. It included patients' expectations that:

- Seeing an osteopath would allow them to gain control of their problem;
- The osteopath would provide an explanation and help them understand their problem;
- They would gain control over their pain even if it involved financial sacrifice.

The survey found (Table 5.4) that expectations were strong in relation to individual agency, with four statements having a very high level (level 4) of positive agreement from respondents. These four expectations were well met, with very low level (0) of unmet expectation for all except being given advice on how to prevent the same problem happening

again, which was unmet moderately often. Osteopaths appeared to support patients' individual agency well.

Note the high proportion of "important" expectations from free text responses (labelled ✎) in the "Need to know" category. This may suggest that the profession needs to place more emphasis on these aspects, especially advice for prevention of recurrence. Almost no patients expected to be able to negotiate the costs of treatment.

Table 5.4 Theme 1: Individual Agency

Q	Patients' Expectations	Frequency of expectation	Level of unmet expectation	Clause in Code
	Take control			
37	To be able to ask questions	4	0	22
38	For questions to be answered to their satisfaction	4	0	17
46	To be given a timeframe for improvement of their symptoms	2	3	21
	Need to know			
31	To be given a clear explanation of their problem, that they can understand	4	0	17
44	To be given advice on how to prevent the same problem happening again	4	2	n/a
24	To be given a clear osteopathic diagnosis of their problem at the first appointment.	3	0	21
✎	*There will be a clear treatment plan and timescale set out*			21
✎	*To be freed from the need for medication or other medical intervention*			73
✎	*To be given a clear and honest explanation of their problem and what can be achieved*	❄		1,21
✎	*To be given advice on how to manage their problem and prevent recurrence/worsening of symptoms*	❄		n/a
✎	*The osteopath will quickly identify the nature of their problem*			21
	Financial sacrifice			
34	To forgo some luxuries to be able to afford osteopathic treatment	3	4	n/a
32	To be told how many treatments they will need at the first appointment	2	2	n/a

4	To be able to negotiate the cost of their treatment sessions if necessary	0	4	128

5.6 Expectations of professional expertise

The literature provided some evidence that technical skill was important to osteopathic patients. This was explored and expanded in depth in the qualitative phase; the findings were that osteopathic patients expected aspects of professional expertise such as:

- The osteopath would have specialist knowledge and skills of their musculo-skeletal and related health problems;
- The osteopath would have a wider knowledge of other types of health care and links; for referral purposes and advice to other healthcare professionals;
- They could trust the osteopath to behave in a professional manner with clear boundaries.

The survey found (Table 5.5) that the level of positive expectations was high (3) or very high (4) for most statements in this theme, with one of the top expectations (❄) being in the specialist knowledge section. The level of unmet expectations was low or very low for most statements, but tended to be higher in the "Open-minded to other therapies" category, where there were a number of worst met expectations (■). This finding confirmed the suggestion from the literature review that the profession could enhance and perhaps make more explicit the process of effective triage at first appointment, with referral if required.

Osteopaths appeared to meet expectations of professional expertise, apart from being open minded to other therapies.

Table 5.5 Theme 2: Professional Expertise

Q	Patients' Expectations	Frequency of expectation	Level of unmet expectation	Clause in Code
🕮	**Specialist knowledge**			
8	The practice displays evidence of the osteopaths professional qualifications	4	1	126
17	The osteopath will take a detailed account of their clinical history	4 ❄	0	66,116
✎	*The osteopath will take a detailed history and carry out a thorough examination prior to treatment*			66,116
✎	*The osteopath will have good knowledge of their particular problem*			66
	Open-minded to other therapies			
39	To be asked about the effects of previous treatment	3	3 ■	73
40	Communication between their osteopath and their GP if necessary	3	3 ■	77
41	The osteopath will refer them elsewhere if their symptoms are not improving	3	3 ■	73
✎	*To be referred to other sources of treatment or help if this is necessary*			73
	Clear boundaries			
13	I expect the clinic environment to be hygienic and professional looking	4	0	133
21	I expect to be given privacy when undressing for diagnosis and treatment.	2	1	45
22	I expect to be provided with a gown or towel when undressed.	2	4	46
✎	*The osteopath will behave in a professional and confident manner*			7

5.7 Expectations about the customer experience

The literature review suggested that osteopathic patients had expectations of a healing environment, an accessible service and flexibility of appointments. These were confirmed and expanded in the qualitative phase, which found expectations that:

- The practice would offer flexibility in appointment times, and see them quickly if they were in severe pain;
- The service offered would be flexible and value-for-money, delivered in an environment that promoted rapport-building and healing.

The survey questionnaire contained a considerable number of expectations within this theme (Table 5.6) and the level of positive expectations was high for the majority. There were five statements with high (level 3) and five with very high (level 4) levels of positive expectation. One aspect (marked ❄) was the highest scoring of all expectations – that the osteopath would treat only one patient at a time – and was met only moderately well. This top expectation perhaps reflects expectations of value for money. Busy practices having several patient cubicles operating in parallel, and even osteopaths answering the telephone to other patients during a treatment session may contravene the patient's expectation of personal care.

There were also three aspects with high or very high levels of unmet positive expectations, marked ■; and of these, the expectation of being given information about how to make a formal complaint was the worst met of all expectations. This theme therefore raised serious implications for practice. Osteopaths appear to fall short in aspects of the customer experience.

Table 5.6 Theme 3: Customer Experience

Q	Patients' Expectations	Frequency of expectation	Level of unmet expectation	Clause in Code
	Building rapport			
20	The osteopath will make them feel at ease	4	0	2
1	Before the first treatment, to be given information about what will happen during treatment	3	2	17, 123
11	To be offered a chaperone or permitted to bring their own if they wish	1	3	49
✎	*There will be a friendly, relaxed atmosphere in the practice*			2
🕮	**Healing environment**			
15	The osteopath will only treat one patient at one time	4 ❄	2	18
12	The waiting area to be comfortable and relaxing	3	0	2
✎	*The practice environment will be clean and hygienic*			133
🕮	**Accessibility**			
5	To be given a choice of appointment times	4	0	67
43	To be able to phone the osteopath for advice if needed	4	3 ■	67
51	The practice will make provision for people with disabilities	3	3 ■	131
9	To have the choice of a male or female osteopath	1	3	n/a
✎	*The osteopath will be readily available as needed, and flexible about appointment times*			67
	Value for money			
33	The osteopathic treatment will be value for money	4	0	128
14	The consultation will last at least thirty minutes	3	0	n/a
50	If they are not satisfied with any part of their treatment, to be given information about how to make a formal complaint	3	4 ■	94
✎	*The cost of treatment will be reasonable and value for money*			128,8

5.8 Expectations of the therapeutic process

The literature review suggested that osteopathic patients expected that the therapy would provide effective manual treatment, physical realignment of the spine as well as advice and prescription of exercise; these would be given within an holistic approach, and would result in reduction of pain and improved quality of life; and the osteopath would offer a level of shared decision-making that was tailored to the patient's preference. The qualitative part of the study expanded on these and found that patients expected that:

- The duration of consultations would provide sufficient time for thorough examination, diagnosis and manual treatment;
- The treatments would be spaced at appropriate intervals to improve symptoms;
- The osteopath would provide an estimate of the likely course of treatment and outcome, for example, the number of treatments that might be required before relief of symptoms;
- The osteopath would provide treatments for their problems that were effective and reduced the patient's need for medication;
- They would not be exploited by being given treatment when there was little chance of improvement, or being advised to return for unnecessary follow-up;
- On-going maintenance treatments would be offered as an option, if required;
- They would be involved in planning treatment and in self-management if they wished.

The survey contained a large number of expectations within this theme, but few emerged with high or very high levels of positive expectation (Table 5.7). There were also no poorly met highly positive expectations (none marked ■). It appeared that osteopathic private practices were meeting patients' expectations about therapeutic process, however information-giving was rather weak; patients may benefit from pre-information about the nature of treatment and likely after-effects, and reassurance about the level of pain experienced during treatment.

Two findings which emerged clearly were that patients did not expect treatment to be painless, nor did they expect electrotherapy. There appeared to be mixed views about whether osteopathy would be gentle or vigorous, and about the after-effects of treatment.

There were a high proportion of statements with no corresponding clause in the Code of Practice within this theme, which seems surprising, especially considering the number of expectations which many patients classed as "important" (✍ statements with ❄).

Table 5.7 Theme 4: Therapeutic process

Q	Patients' Expectations	Frequency of expectation	Level of unmet expectation	Clause in Code
	Nature of the intervention			
23	The osteopath to identify the problem area with her/his hands.	4	0	n/a
2	To be given an explanation of what the treatment will involve before it is given	3	1	17
3	To be given information about the benefits of treatment	3	1	19
25	The osteopathy treatment to be vigorous	1	1	124
26	The osteopathy treatment to be gentle	1	0	124
27	To receive electrotherapy e.g. ultrasound	0	4	124
35	The treatment to be painless.	0	0	n/a
✍	*To receive appropriate, effective treatment*			66
✍	*The osteopath will take a holistic approach to my care*			n/a
✍	*To receive hands-on, gentle/pain-free treatment*			n/a
✍	*The treatment to be vigorous/painful*			n/a
🕮	**Impact on symptoms**			
28	The osteopath will monitor my reaction to his/her treatment	4	0	n/a
36	The symptoms may get worse following treatment	2	3	n/a
47	The symptoms to improve within the given time frame	2	0	66
48	To feel some pain or discomfort following treatment	2	2	n/a
49	To be able to return to normal activities soon after treatment	2	0	66

✎	*There will be an immediate, perceptible improvement in symptoms*	❄		66
✎	*To be able to return to normal activities or have an improved quality of life*	❄		66
✎	*The problem to eventually resolve completely as a result of the treatment*	❄		66
	Session duration			
14	The consultation to last at least thirty minutes *(see Focus group discussion about expectation of some treatment within the consultation)*	3	0	n/a
🕮	**On-going maintenance**			
✎	*To be able to receive ongoing monitoring of the problem over time*			n/a
	Degree of involvement			
42	To be given advice about how to manage the symptoms themselves	4	1	n/a
19	To be involved in making decisions about their treatment	3	1	n/a
45	To be given activities or exercises to do at home	3	2	n/a
✎	*To be given advice on how to manage their problem and prevent recurrence/worsening of symptoms*	❄		n/a
✎	*To be encouraged to be actively involved in discussion and decision-making about their treatment*			n/a

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5.9 Expectations of interpersonal relationship

The literature review suggested that patients expected the osteopath to have good inter-personal skills; to offer the patient hope, communication, and respect; and to build trust. The information gained in the focus groups with osteopathic patients suggested that they expected that:

- A trusting inter-personal relationship with the osteopath would be possible, with the osteopath believing them, taking their problem seriously and caring about the outcome, and the patient having confidence in the practitioner.

The survey findings (Table 5.8) showed that the level of positive expectations within this theme was mainly very high, with three top expectations indicated by ❄. The level of unmet expectations was also very low for most aspects; osteopaths appeared to be particularly good at these aspects of care. The exception was within the "Trusting relationship" category, where there were high levels of unmet expectation (marked ■) in relation to being given information about risks and side effects of treatment, and being reassured that the information that the patient provided would be kept confidential. 17% of respondents considered that they were not reassured about of confidentiality. This does not mean that confidentiality was breached, but that reassurance was not given. Given the high level of patients' expectations about interpersonal relationship, the results suggest that these two areas of practice – provision of risk information and reassurance of confidentiality - require improvement as a matter of priority.

One surprising result was that a consent form was not expected by the majority. However, for those patients who did expect to sign a form, their expectations were often unmet - it did not happen. In view of the dichotomy of views, further research is needed to gain understanding of the needs of patients. It may be helpful to the profession to make the consent process more explicit e.g. use of a consent form or explicit discussion with the osteopath. The wording of this question could be changed for future use.

Table 5.8 Theme 5: Interpersonal relationship

Q	Patients' Expectations	Frequency of expectation	Level of unmet expectation	Clause in Code
🕮	**Being believed**			
29	To be treated with respect	4 ❄	0	62
30	The osteopath to listen to me	4 ❄	0	2
🖉	*The Osteopath will be caring and listen to what I have to say*	❄		2
🕮	**Trusting relationship**			
6	To be given information about the risks and side effects of treatment	4	3 ■	20
16	To be reassured that the information that they are asked to provide will be kept confidential	4 ❄	3 ■	104
7	To sign a consent form prior to treatment	1	3	24-36

✍	*To be treated with respect and confidentiality*			62, 104
✍	*To feel safe, and able to trust the osteopath*			1
🕮	**Sense of connection**			
10	To see the same osteopath each time	4	0	n/a
18	The osteopath will be sympathetic and caring	3	0	2

5.10 Limitations of the evidence

As this was the first study of its kind, the study design aimed for scientific rigour and results that represented the majority of current patients. The random/systematic sample of patients in the survey provided a representative (and uniform) profile of current, private osteopathic practice. The literature review was complete and stands on its merits as current evidence on expectation in healthcare generally. Both the qualitative and quantitative parts of the study have the status of extended pilot studies that need confirming by further research. Further research is needed both to confirm the findings and to extend the survey into different populations.

The qualitative phase of the study included all three osteopathic service models – private, OEI and NHS services. The thematic model of expectations which emerged appeared to be valid for all three service models, although the sample sizes were small for the OEI and NHS services and further research is needed. The sample sizes were also too small to test the validity of the thematic model in minority populations.

In the survey in private practices, the response rate was rather low, there was limited diversity in the patients within private practices, and the questionnaire was not yet validated. The patient sample was fairly homogeneous: educated, white, and in employment, generally typical of private osteopathic patients. The numbers of survey respondents from minority groups were too small for a meaningful sub-group analysis: for example there were fewer than 30 non-white respondents, 19 with poor general health, and 55 unemployed. The patients were mainly long-term rather than new patients, hence recall of their initial expectations of osteopathy was coloured by subsequent experience. However, the fact that unmet

expectations of new patients, which were analysed separately, were very similar to those of the returning patients, suggested that the results apply to both new and returning patients.

The evidence about the effect of patient characteristics provided by the literature review, and the views of diverse patients in the focus groups, suggested that the study had identified most of the expectations that diverse patients would have about osteopathic care. However, further research to obtain more detailed information on expectations of minority groups, of new patients, and of patients in OEI and NHS practices would require study designs which purposely recruited these groups.

Barriers to participation

The concerns about participation by osteopaths are identified here as they may be useful for future research; the same issues may also be potential barriers to effective dissemination, especially where change in practice is implied. The concerns were various:

- Anxieties about involvement in academic research, especially research concerning practice quality, partly due to limited experience of research;
- Confidentiality of the osteopaths' identity: the information sheet for osteopaths stated that the identity code on each questionnaire could be broken in the unlikely event that a returned questionnaire suggested serious misconduct on the part of an osteopath. The research team can now assure the profession that was no evidence of serious misconduct in the responses;
- Suspicions about whether the "agenda "for the study was a desire by GOsC to define or limit scope of practice; we understand that the motivation from GOsC to undertake this project was to fulfil their political remit to focus on quality of care and patient-centred treatment; all regulators are engaged in fulfilling their responsibility to listen to the patient's viewpoint;
- Whether the findings of the study might be used by GOsC to set unrealistic professional targets and standards, to "out-law" specific procedures or, conversely, to enforce for example written consent, treating only one patient at a time, negotiation of fees, or display of qualifications;
- The professional standards might become based on giving patients what they wanted, at the expense of good individualised care;

- The survey methodology was a blunt instrument; this is a valid concern; and the reason why we also used in-depth one-to one interviews and focus groups;
- The questionnaire for having too many questions, or 'leading' questions that might influence the expectations of the patients involved.

5.11 Implications for the Regulator

The GOsC envisaged that the outputs from the study might be used for timely, targeted guidance to the profession on practice issues. The survey has identified very precisely the priority areas that could be targeted. These are the areas where the level of unmet expectations was high, marked ■ in Tables 5.4-5.8. There was one aspect of care where the level of unmet positive expectation was very high

- Being made aware that there was a complaints procedure should they need to use it.

There were a number of other aspects where the level of unmet positive expectation was high:

- Communication between the osteopath and the patient's GP about their problem;
- The osteopath being able to refer them elsewhere when their symptoms did not improve;
- There being access for people with disabilities;
- Being given the opportunity to receive advice from the osteopath over the telephone;
- The patient being informed of the risks and side effects of treatment;
- Being asked about the effects of previous treatment;
- The osteopath assuring them that their details were kept confidential.

The Osteopathic Code of Practice has played an important role in this project, firstly as a source of possible topics for the survey and secondly, at the end of the project, to identify expectations that were not covered by the Code. These are all shown in Table 5.9 below and were marked as "n/a" in Tables 5.4.-5.8. It is remarkable that many of these issues without clauses relate to Individual Agency or Therapeutic Process, and are ones for which expectations were not well met, especially for new patients (see Table 4.9). The Regulator

will now be able to consider whether or not missing topics should be considered when the Code is next reviewed.

The five-component thematic framework for patient expectations provides a patient-centred way to group the various aspects of care, which could perhaps be useful as a framework when GOsC next revises the Code of Practice.

The final exercise was a mapping of all the patients' expectations against the Code, to identify which clauses had no corresponding patients' expectations within this study. This comparison is shown in Table 5.10 which is located at the end of the Chapter. It shows that some Clauses could perhaps be expanded to cover more aspects of patient expectation.

Table 5.9 Expectations with no relevant clauses within the Osteopathic Code of Practice

Q survey question
✎ *free text from participants*

	Individual Agency
Q	I expect to be given advice on how to prevent the same problem happening again
✎	*I will be given advice on how to manage my problem and prevent recurrence/worsening of symptoms*
Q	I would forgo some luxuries to be able to afford osteopathic treatment
Q	I expect to be told how many treatments I will need at my first appointment
	Customer experience
Q	I expect to have the choice of a male or female osteopath
Q	I expect the consultation to last at least thirty minutes
	Therapeutic process
Q	I expect the osteopath to identify my problem area with her/his hands.
Q	I expect treatment to be painless.
✎	*I will receive hands-on, gentle/pain-free treatment*
✎	*The treatment will be vigorous/painful*
Q	I expect the osteopath to monitor my reaction to his/her treatment
Q	I expect my symptoms may get worse following treatment
Q	I expect to feel some pain or discomfort following treatment
Q	I expect the consultation to last at least thirty minutes (Note: the focus group discussion suggested an expectation of some treatment within every appointment)
✎	*I will be able to receive ongoing monitoring of my problem over time*

Q	I expect to be given advice about how to manage my symptoms myself
Q	I expect to be given activities or exercises to do at home
✎	*I will be encouraged to be actively involved in discussion and decision-making about my treatment*
	Inter-personal relationship
Q	I expect to see the same osteopath each time
✎	*The Osteopath will take a holistic approach to my care*

5.12 Implications for the osteopathic profession

In this section, the implications identified in each of the three phases are brought together, and compared.

Identification of the important issues allows the profession to set priorities: these apply to the regulator in respect of the standards, to educators in respect of training, and to private practices in respect of service delivery. The gaps between expectations and delivery of care have a negative effect on outcomes of care, as emphasised by the literature review; reducing these gaps can be achieved by improving care and/ or managing expectation better,

Implications of the literature review

The main implications for osteopathy emerging from the literature were the need for the profession and individual practitioners:

- To explicitly identify and actively understand patients' expectations in order to increase satisfaction;
- To provide evidence-based health advice that avoids raising unrealistic expectations;
- To use efficient triaging with referral where necessary;
- To exhibit professional behaviour;
- To provide an organised and effective service;
- Provision of an indication of the prognosis;
- To engage in goal-setting for patients based on identified expectations of outcome in order to ensure concordance and prevent unrealistic expectations;
- To document expectations and outcomes more closely with patients, perhaps using validated outcome measures and assessment tools routinely;

- To provide effective communication and care which is attentive to the patient's concerns.

Implications of the focus groups and interviews

The findings of the focus groups and interviews confirmed and expanded on the above, with wide-ranging implications for the delivery of osteopathic services. The many aspects of osteopathic patients' expectations were identified and grouped into five main themes: individual agency, professional expertise, customer experience, therapeutic process and interpersonal relationship. These themes appeared to be common to all types of service model: private practice, OEI training clinics and NHS practices.

Implications of the Survey

The findings of the survey were consistent with, and supported strongly, the implications drawn out from the previous phases of the project. 48 out of the 51 statements about expectation were positively endorsed by the patients within the survey, and the results as a whole define more clearly for the profession what patients expect when they seek private osteopathic care.

In addition, the survey ranked the aspects of expectation of patients in private osteopathic practice; and quantified the extent which expectations were unmet, allowing priorities to be set for improving private practice. Note that the priorities for NHS osteopathic services may be different: although the same aspects of expectation arose in the qualitative phase, the ranking of expectations and the extent to which expectations are met were not evaluated within this study.

Implications of the study as a whole

For the profession, the implications related to improving the delivery of care within private practice; the priorities are underlined in the list below.

Firstly, patients expect their osteopath to support their **individual agency**:

- To help the patient to gain control over their problem; they may already know a lot about their problem, may well have consulted doctors and other manual therapists

previously, including osteopaths, and may have preferences about the sort of osteopathy they want to receive;

- To support a patient's need to know about their problem, by providing clear information and advice about the problem and on how to prevent it recurring;
- To empower the patient to take control themselves, where possible, for example utilising home exercises or advice;
- To appreciate the vulnerability imposed by suffering pain or by financial sacrifice if that is necessary.

Patients expect their osteopath to demonstrate evidence of **professional expertise**:

- To provide a good explanation of the causes of the patient's problem at the first visit, and to provide relief of symptoms within a reasonable timeframe;
- To observe clear boundaries especially in respect of the undressing and the intimacy of touch which may be required. The intimacy of contact during osteopathic treatment places a huge responsibility on the practitioner for maintaining a professional manner; patients held up GPs as the benchmark in this respect;
- To inform patients about the need and reasons for undressing, prior to their first visit;
- To have a broad knowledge of other types of health care and to refer to other healthcare professionals if appropriate (this is quite challenging especially for newly-fledged practices as local links to other health care professionals take time to forge)
- To enhance and perhaps make more explicit the process of effective triage at first appointment, with referral if required.

Patients expect their osteopathic practice to offer a quality **customer experience**:

- To provide details about the nature of the osteopathic intervention at an early stage in the pathway;
- To ensure that the way the practice is organised, the training of staff and osteopath(s) in customer care, the atmosphere within the practice, and the dialogue around payment and frequency of follow-up are sensitive to patients; if these expectations are met, then this will contribute to both satisfaction and clinical outcomes;
- The osteopath should treat only one patient at a time (note that this was the highest of all patients' expectations); if this level of personal service is not provided, for

example when several patient cubicles are operating in parallel, or the osteopath answers the telephone to other patients during a treatment session, patients should be informed prior to attendance ;

- Ensuring that patient confidentiality is respected by all staff within the practice, including receptionists;
- Providing information about how to make a formal complaint (note that this was the worst met of all expectations).

Patients expect their osteopath to provide a patient-centred **therapeutic process**:

- Communicating realistic expectations about the impact of treatment on their symptoms;
- Providing accurate information about risks, and to advise on safe treatment options
- To take safe decisions for patients who want to trust the osteopath to make all decisions about their treatment;
- Informing patients about what to expect in relation to treatment and outcomes including side-effects; it is helpful to provide pre- attendance information about the nature of treatment and the likely after-effects, and reassurance about the level of pain that might be experienced during treatment.

Patients expect and value their **interpersonal relationship** with their osteopath and expect the osteopath to:

- Explore the patient's preferences for and attitudes to involvement in their care;
- Nurture a professional inter-personal relationships with patients;
- Provide two types of information to meet patients' concerns – about risks and side effects of treatment and reassurance of confidentiality; osteopaths need to provide these more consistently and as a matter of priority;
- Make the consent process more explicit e.g. using a consent form or obtaining verbal agreement explicitly after explanation and dialogue with the patient.

Setting priorities

It would seem prudent not only to prioritise the very poorly met expectations underlined above, but also to prioritise (i) expectations that can be met easily, where simple changes in practice could diminish the gap between expectation and delivery, without compromise to the healing environment or therapeutic relationship; (ii) all moderate, high and very high unmet positive expectations and (iii) expectations that seem basic aspects of professional practice such as routinely offering towels or gowns for modesty, and hygiene.

Managing expectations may also be important for the profession in order to prevent disappointment or unrealistic expectations. For example, patients can be given information and explanation about the need to undress and cost structures before attending, so that they know what to expect. If there are preferences and choices available in the gender of the osteopath or the type of osteopathy (or other therapies) used by the osteopath, which could also be explained. If the osteopath is so busy within the practice, or in demand on the telephone, that personal levels of care are compromised, then the patient needs to be forewarned that they will not have exclusive attention from the osteopath. There may be a need to manage expectations during the consultation, about anticipated pain levels during and after treatment, and about the certainty or uncertainty of the diagnosis and prognosis, and how this may change over time. The expectations of an "immediate, perceptible improvement in symptoms" and "my problem resolving completely as a result of treatment" may need to be managed, as the osteopath thinks fit.

There were two issues which featured high in the list of unmet expectation, which may need further investigation in order for the profession to know how to address them. One was about communication with the patient's GP. It appears to be high in patient priorities and poorly met by osteopaths. Similarly, signing a consent form prior to treatment. Although many patients did not expect this, a substantial proportion did, and their expectation was often unmet.

5.13 Implications for education and training

For education and training, the findings about patient-centred care, the important expectations, unmet expectations, and well met expectations should be considered against the current curricula within the Osteopathic Educational Institutions. This newly gained understanding of patient expectations within osteopathy, and the relationship with outcomes, needs to be emphasised in education.

Both for professional training and for CPD, the main implications involved the need for training and support beyond the scope of osteopathic technique and professional practice, and particularly in the following areas:

- Interpersonal skills, such as communication skills and empathy;
- Personal development and psychological health;
- Evidence and judgement of clinical risks;
- Professional conduct and boundaries in respect of touch and clinical examination; perhaps incorporating aspects of medical clinical training, to develop a "GP-like" approach to touch;
- A broad knowledge of other types of health care and how to forge links with other healthcare professionals for referral purposes.

5.14 The main findings

The main findings of the study were that patients' expectations of osteopathic care are complex and encompass over 50 aspects of care; in private practices in the UK, most of the expectations of patients were met and a very high proportion of patients were satisfied with their care. There were a few expectations which were found to unmet in private practice for more than 10% of patients; identification of such gaps in the quality of the service will enable the profession to improve the quality of osteopathic services for the future.

Table 5.10 Expectations mapped onto Code of Practice

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
1-2 Relationships with patients	***1 A trusting relationship is essential***	O 5	I will be given a clear and honest explanation of my problem and what can be achieved
		f 23	I will feel safe, and able to trust the Osteopath
	2. Put patients first – aware of anxiety, vulnerability, unrealistic expectations	20	I expect the osteopath to make me feel at ease
		f 15	There will be a friendly, relaxed atmosphere in the practice
		12	I expect the waiting area to be comfortable and relaxing
		30	I expect the osteopath to listen to me
		f 2	The Osteopath will be caring and listen to what I have to say
		18	I expect the osteopath to be sympathetic and caring
3 - 7 Personal relationships with patients	*3 Close personal relationships must not be pursued*		
	4 Conduct must not imply willingness to be close		
	5 Stop treating if in doubt		
	6 Facilitate transfer to another practice if ending relations		
	7 Maintain clear boundaries for objective clinical judgement	f 10	The Osteopath will behave in a professional and confident manner
8 Undue influence on patients	***8 Do not exploit patients, for example with unnecessary investigation, prolonged treatment, pressure to purchase products or services, unreasonable fees***	f 9	The cost of treatment will be reasonable and value for money *(this issue of exploitation is also mentioned in the Qualitative chapter)*
9 - 11 Financial	*9 Honest and reliable financial dealing*		

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
and commercial activities	*10 -11 Declare financial interests in any products and services you promote*		
12 - 13 Insolvency	*12 Notify GOsC* *13 Report back to GOsC*		
14 Criminal convictions	*14 Notify GOsC*		
15 Civil proceedings	*15 Notify GOsC*		
16 Other professional bodies	*16 Notify GOsC of investigation by a professional body*		
17 - 22 Communicating with patients	***17 Information is heard and understood by patient***	38	I expect my questions to be answered to my satisfaction
		31	I expect to be given a clear explanation of my problem that I understand
		1	Before my first treatment I expect to be given information about what will happen during treatment.
		2	I expect to be given an explanation of what the treatment will involve before it is given
	18 Patient has your undivided attention	15	I expect the osteopath to only treat one patient at one time
	19 Patient knows what to realistically expect	3	I expect to be given information about the benefits of treatment
	20 Explain the risks of treatment	6	I expect to be given information about the risks and side effects of treatment
	21 Help patient understand their condition and the treatment options available	46	I expect to be given a timeframe for improvement of symptoms
		f 17	There will be a clear treatment plan and timescale set out
		24	I expect to be given a clear osteopathic diagnosis of my problem at my first appointment.
		f 5	I will be given a clear and honest explanation of my

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
			problem and what can be achieved
		f 8	The Osteopath will quickly identify the nature of my problem
	22 Encourage questions	37	I expect to be able to ask questions
23 - 36 Consent	***23 Obtain their consent for the care you propose***	7	I expect to sign a consent form prior to treatment
	24Obtain informed consent for examination and treatment specific to each procedure		
	25 Ensure patient has consented		
	26Renew consent in on-going care		
	27 Carefully ensure consent for intimate areas		
	28Writen consent for vaginal or rectal examination		
	29Patients without capacity for informed consent may be unable to consent *30 Adult involved in daily care may consent on their behalf*		
	31 Children must consent to examination or treatment if possible *32Over the age of 16, parents cannot over-ride their consent* *33Under 16s may have capacity to consent* *34Involve the parent or guardian where possible* *35 Encourage child to bring a chaperone if they refuse parent* *35A competent child's consent cannot be over-ridden by parent/ guardian but child's refusal can be over-ridden*		
37 - 44 Examining and treating intimate areas	*37 Good communication important in these areas* *38 Explain what needs to be done and why, obtain consent*		

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	39 Chaperone must be offered *40Vaginal or rectal examination should be conducted at next appointment to give patient time* *41 Be sensitive to patient unease* *42 Respect modesty and hygiene* *43Afterwards, allow patient to put underwear on before continuing* *44 Disposable gloves must be worn*		
45 – 48 Patient modesty	***45 Undress only if required, with privacy for undressing***	21	I expect to be given privacy when undressing for diagnosis and treatment.
	46 Cover (towel or blanket) during treatment	22	I expect to be provided with a gown or towel when undressed.
	47 Modesty to a professional standard, sensitive to patient		
	48Sensitive to patient culture and experiences		
49 – 52 Chaperones	***49 Chaperone is chosen by patient*** ***50 if none available, make another appointment*** *51 always have a chaperone for children under 16, treatment of intimate areas, patients at home, or if patient requests it* *52 Record presence of chaperone on case-notes*	11	I expect to be offered a chaperone or permitted to bring my own if I wish
53 - 57 Patients rights in teaching or research	*Ethical approval needed; patient consent to participate; no pressure to take part; truthful records; anonymised*		
58 - 61 Visual and audio recordings of patients	*Recording requires consent; use least obtrusive means; store securely to prevent unauthorised access*		
62-68 The Duty of Care	***62 Treat patients with respect, put their well-being first***	29	I expect to be treated with respect.

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	63 Care not prejudiced by culture, ethnicity, gender, beliefs, attitudes		
	64 Use sign/ interpreter to assist communication if needed		
	65 if you discontinue or refuse treatment, you must inform patient and facilitate finding alternative care		
	66 Duty to provide good quality care including full case history, examination, and competent treatment or referral	17	I expect the osteopath to take a detailed account of my clinical history.
		f 21	The Osteopath will take a detailed history and carry out a thorough examination prior to treatment
		f 19	The Osteopath will have good knowledge of my particular problem
		f 7	I will receive appropriate, effective treatment
		47	I expect my symptoms to improve within the given time frame
		49	I expect to be able to return to my normal activities soon after treatment
		f 1	There will be an immediate, perceptible improvement in symptoms
		f 3	I will be able to return to my normal activities/have an improved quality of life
		f 6	My problem will eventually resolve completely as a result of the treatment
	67 Clear information about when patients can access the osteopath	5	I expect to be given a choice of appointment times
		43	I expect to be able to phone the osteopath for advice if I needed
		f 11	The Osteopath will be readily available as needed, and

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
			flexible about appointment times
	68 Ensure clear communication with other healthcare professionals caring for pt.		
69 - 71 Your contact with the patient	*69 Terms of your contractual relationship made clear to patient, what you can and cannot offer*		Note: difficulties in finding out what modalities were provided within a practice was mentioned in the qualitative interviews
	70 Osteopath responsible for using professional knowledge and skills, all staff properly trained *71 Osteopathic care cannot be delegated to a non-osteopath*		
72 Home/domiciliary visits	*72 Standard of Care equivalent to that within practice-suitable treatment table, avoid bed; record as home visit in notes*		
73 - 76 Relationships with colleagues	***73 Cooperation with other professionals to secure most suitable care for the patient***	f 22	I will be freed from the need for medication or other medical intervention
		39	I expect to be asked about effects of previous treatment
		41	I expect the osteopath to refer me elsewhere if my symptoms are not improving
		f 25	I will be referred to other sources of treatment or help if this is necessary
	74 Sole practitioners - establish a network of professionals		
	75 Refer to competent, indemnified professional; provide relevant information, with patients consent		
	76 Osteopathic care not in relationship with non-osteopaths		
77 - 79 Relationships with GPs	***77 Encourage patients to inform their GP***	40	I would expect there to be communication between my osteopath and GP if necessary

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	78 Obtain patients consent to request or release information to GP		
	79 Communication should be professional and recorded in case-notes		
80 – 81 Comments about colleagues	*80 Comments honest, accurate* *81 Duty to protect patients if colleague may pose threat*		
82 - 83 Professional standards	*82 Competence maintained by CPD* *83 Prompt response to professional or GOsC enquiries re Clinical records or complaints*		
84 - 86 Personal standards	*84 Proper personal standards of conduct at all times, no dishonesty, violence, criminal activities* *85 Registration could be refused* *86 Must not practice under influence of alcohol/ drugs*		
87 - 88 What the law requires	*87 Act within the law* *88 Obtain legal advice if problems occur*		
89 - 90 The right to practise	*89 Valid registration needed to use title osteopath* *90 Practice abroad depends on law in that country*		
91 Professional indemnity insurance	*91 Must have adequate PII*		
92 - 93 Legal limitations on what an osteopath can do	*92 Osteopaths prohibited from certain Advertising, procedures, prescription of medicines, medical-only certification, treating animal without vet referral*		
	93 Practice as a member of another healthcare		

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	profession if registered and hold PII		
94 - 99 Complaints	***94 Patients may sometimes be unsatisfied with their care*** ***95 You should operate a procedure for complaints***	50	If I am not satisfied with any part of my treatment I would expect to be given information about how to make a formal complaint
	96 Deal with complaints quickly		
	97 Ensure anyone making a complaint knows they can refer it to GOsC		
	98 Inform your PA and PII immediately		
	99Reflect o practice standards		
100 - 101 Problems with your health	*100 Modify or stop practising as your medical adviser judges; inform GOsC* *101 Stop practicing id serious communicable condition suspected*		
102 - 103 If trust breaks down	*102 If professional relationship and trust has broken down, you can end relationship* *103Faciltate finding alternative osteopathic care*		
104 - 109 The principles of confidentiality	***104 Patients have the right to confidentiality***	16	I expect to be reassured that the information that I am asked to provide will be kept confidential
		f 12	I will be treated with respect and confidentiality
	105 Professional information- Patient's identity, personal information, and clinical details -are confidential; duty extends to staff and after patients' death		
	106 Patients consent needed to discuss their details with family or partner		
	107 Confidential information must be securely stored		
	108 Release of confidential information needs patient consent and they must be informed of the extent of		

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	disclosure		
	109 Explain to patients about likely disclosures in the workplace		
110 - 115 Disclosures without consent	*110 Disclosure of confidential information without consent only when compelled by order of court or other legal authority* *111 May be in the public interest* *112 exceptionally in the interest of patients, only after seeking guidance from PII and GOsC* *113Disclose the minimum* *114 Only release what is requested; take legal advice* *115 Inspector of Taxes may see financial records; keep separate from clinical records*		
116 - 119 Osteopathic records	***116 Case notes must be accurate, signed, dated, comprehensive*** *117 Kept safely a minimum of 8 years* *118 Long enough to respond to legal action* *119 all reports must be honest and accurate*	17 f 21	I expect the osteopath to take a detailed account of my clinical history. The Osteopath will take a detailed history and carry out a thorough examination prior to treatment
120 Data protection	*120 Register with the Information Commissioner if necessary*		
121 Access to records	*121 Patients have a right to access their records*		
122 - 127 Practice information	*122 Advertising decent, honest, truthful comply with CAP*		
	123 provide good information about service	1	Before my first treatment I expect to be given information about what will happen during treatment.
	124 You may indicate special interest and other types	25	I expect the osteopathy treatment to be vigorous

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
	of therapy in practice	26	I expect the osteopathy treatment to be gentle
		27	I expect to receive electrotherapy e.g. ultrasound (*Note: various other types of therapies were mentioned in the qualitative interviews)*
	125 Must not claim superiority or disparage other healthcare professionals		
	126 do not use titles that imply medically qualified unless you are	8	I expect the practice to display evidence of the osteopaths professional qualifications
	127 Publicity can be distributed freely but not cause nuisance to or put pressure on recipients		
128 Fees	***128 Fee scale reasonable and available; patients informed of fee structure in advance of attending***	4	I expect to be able to negotiate the cost of my treatment sessions if necessary
		33	I expect my osteopathic treatment to be value for money
		f 9	The cost of treatment will be reasonable and value for money
129 Your staff	*129 You are responsible for staff complying with this code*		
130 The work environment	*130 Work place safe, hygienic, comfortable*		Note (this clause is assumed to apply to staff; comments from patients on hygiene are under Health and Safety)
131 Disability discrimination Act 1995	*131 make reasonable adjustments to provide access*		
132 Race Relations Act	*132 it is unlawful to discriminate on race*		
133 - 135 Health and safety	***133 You are responsible to compliance*** *134 Must have public liability insurance* *135 Must have appropriate procedures for medical emergency*	13	I expect the clinic environment to be hygienic and professional looking
		f 18	The practice environment will be clean and hygienic

Heading	*Clause in Code of Practice for Osteopaths*	Question no.	Expectations of patients
136 - 141 Students and junior colleagues	*136 Associates or assistants given support and resources* *137 Develop effective teaching skills, if teaching* *138 Permit potential students as observers* *139 Osteopathic students in your clinic must be supervised* *140 Student presence should be recorded in case-notes* *141 Junior colleagues training in clinic should be adequately supervised and PII in place*		

Chapter 6 Recommendations for future research

Summary of chapter 6

Further research is recommended using qualitative methodologies to test the model developed within this project and to extent it to populations served by osteopathy. Further survey research is recommended to confirm the current findings and to evaluate expectations within different populations of osteopathic patients.

6.1 Recommendations for future qualitative research

The conceptual framework generated in this study can be considered as a new hypothesis which requires testing in further research. Using the same type of methodology, further interviews and focus groups would target specific populations and compare and contrast findings of the analysis. Further testing is required with participants drawn from:

- Private practices in different locations within the UK;
- Private practices in catchment areas with greater ethnic and social diversity;
- Private practices targeting non-returners in order to investigate sources of dissatisfaction and unmet expectation;
- Other osteopathic service models – Osteopathic Educational Institutions and NHS services;
- The general public, in order to access people with no experience or adverse experience of osteopathy;
- The osteopathic profession in order to compare their expectations of the service with those of patients;
- The topics discussed within further interviews could be expanded to provide; further exploration of the unexpected findings identified above, and to gain more understanding of unmet expectations.

6.2 Recommendations for future quantitative research

It would be valuable to extend the findings from the survey in a number of different ways:

- Utilising the existing dataset further, to explore the impact on expectations of some patient characteristics - such as age, gender, prior experience, new patient or not, acute presentation or not; these data represent a rich resource for the profession;

- The questionnaire should be modified a little in the light of the experience gained in the project, as a resource for further surveys, nationally, regionally and within Osteopathic Educational Institutions; suggested modifications to the questionnaire are given in Appendix 12.

- Further surveys are required (a) to confirm the findings of this study; (b) to explore differences in other osteopathic settings such as Osteopathic Educational Institutions and the NHS services; in specific areas serving different social groups; and at intervals in order to explore changes over time. Surveys within the OEI patient population would be easy to conduct and willingness to do so was expressed by the two Osteopathic Educational Institutions where focus groups were held. NHS practices would need to be identified and targeted to expand the sample size and heterogeneity of service.

6.3 Additional areas for further research

- Exploring poorly met expectations using qualitative methods such as interviews with the osteopaths and with patients to better understand why certain expectations were poorly met in practice, and whether there is scope for, or a need for, changes in practice.

- Patient diversity can be explored in selected practices have a very different patient profile, that serve minority groups in the population. Targeting such practices would enable information to be gained about the variation in expectation according to factors such as ethnicity, deprivation, and disability. A maximum diversity strategy was included in the original project proposal but was dropped in order to concentrate on obtaining rigorous baseline data. Such a project would be more meaningful and practicable when figures for uptake of osteopathy by different ethnic groups are available; the SDC project may provide some information in this respect.

- Patients' expectations of treatment could be explored further, since the literature provided little about expectations of treatment (such as modalities, qualities, nature, and mode of delivery); treatment is central to delivery of effective care and outcomes.

- Research into osteopaths' views of patients' expectations would permit exploration of discordance and concordance between the views of patients and practitioners.

Chapter 7 Conclusions

Summary of Chapter 7

The study methodology generated robust and valuable data at each stage, and answered the initial research questions. The research generated rich data for the profession, for the training establishments, the Regulator and for patients. Material for disseminating the results to these target audiences will be produced in liaison with the professional organisations within osteopathy. The methodology and the questionnaire are now resources for future research, including surveys in other settings such as OEI clinics or NHS services.

The profession is now able to guide patients about what is reasonable to expect when they visit the osteopath. Patients can confidently expect that they will be treated with respect, listened to, and provided with a good explanation of their problem. Patients may need to understand that certain expectations are hard to meet, such as a choice of male or female osteopath, or telephone advice from the osteopath.

7.1 The main results of the project

The project has provided robust answers to the research brief, and provided a wealth of new evidence about the expectations of patients in osteopathic private practices. The specific aspects of osteopathic practice about which patients have expectations have been identified very fully through three types of methodology; and the extent to which patients perceived that their expectations were met or unmet has been evaluated in depth by the survey.

Knowledge of the variation in expectations according to patients' characteristics and background, including minority groups, has been gained through the literature review and, to some extent, through the focus groups and interviews and the survey, within the limitations imposed by the homogeneity of the population of patients attending private practices.

The project has provided resources for future research: the literature review is a resource for health care in general; the methodology has proven effective and productive for other branches of healthcare to use in investigating patients' expectations; and the questionnaire, which is osteopathy-specific, is well-tested and suitable for future research on expectations within osteopathy. There is a need for further research in a number of areas as outlined in the previous chapter.

The findings showed that satisfaction with osteopathic practice was high, and that many expectations were met to a high degree. There may be some room for improvement in "usual" practice within osteopathy, as well as making aspects of the service more explicit and managing some unrealistic expectations of care. There were a few unmet expectations which may be a cause for concern and which need action within the profession as a priority, and some which need investigating further, particularly the expectations around communication with GPs, and understanding how patients perceive the consent process before treatment. The implications for practice and for patients have been drawn out, and will be developed into documents suitable for distribution to the profession and to patients in liaison with the GOsC and the BOA.

7.2 What patients can reasonably expect when they visit an osteopath

Patients can feel confident in expecting the osteopathic profession to provide the following aspects of care consistently and to a high degree

- To be treated with respect;
- To be able to ask questions;
- For questions to be answered to their satisfaction;
- For the osteopath to listen to them;
- For the osteopath to be sympathetic towards their problem;
- For the osteopath to make them feel at ease;
- For the environment to be hygienic and professional;
- For the osteopath to examine their specific problem area with her/his hands;
- For the osteopath to write down their personal case history;
- For the consultation to last at least thirty minutes;
- To be given an explanation of the cause of their problem that they were able to understand;
- For their treatment to be value for money;
- For manual treatment to be given to the problem area.

The profession is working towards providing the following more consistently; patients should feel justified in expecting and requesting these things:

- Before their first appointment, to be given information about will would happen during treatment;
- Reassurance that the information they are asked to provide will be kept confidential;
- Advice on how to manage their problem and prevent recurrence or worsening of symptoms;
- Information about the complaints procedure should they need to use it;
- Information about the risks and side effects of treatment;
- Access for people with disabilities;
- For the osteopath to be able to refer them elsewhere if their symptoms do not improve;
- To be asked about the effects of previous treatment.

The outcome of treatment will depends on the nature of the patient's problem and their response to osteopathic treatment; the profession endeavours to improve on the effectiveness of treatment through training and research, and to provide as far as possible:

- Appropriate, effective treatment;
- An immediate, perceptible improvement in symptoms;
- To enable the patient to return to their normal activities or have an improved quality of life;
- The patients' problem to eventually resolve completely as a result of the treatment.

There are some aspects of care which some osteopathic practices find are challenging to meet for organisational reasons:

- The osteopath only treating one patient at a time;
- Giving patients the opportunity to receive advice from the osteopath over the telephone;
- Providing a choice of male or female osteopath.

In very busy practices, an osteopath may see several patients in different cubicles. A patient needs to enquire before booking if they have strong feelings about this.

Patients should be aware that communication between private osteopaths and GPs is usually limited, and occurs under specific circumstances, for example if the GP referred the patient to the osteopath, if the osteopath needs further information about the patient's health, or recommends that an investigation is carried out.

Patients can be assured that the profession is taking the findings of this study seriously and will endeavour to improve care where patients have identified gaps between expectation and delivery.

This section will be used to develop, in liaison with the GOsC and BOA, a booklet written in lay language for patients.

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Appendix 1. The research team and their roles

RESEARCH TEAM

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Members of GOsC Council

Jonathan Hearsey

Prof. Ian Hughes

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Evlynne Gilvarry

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Appendix 3. Literature Search Strategy

The main research question for the OPEN project comprises three fields. The search terms were broken down to fit into the PICO format used by Straus *et al*, 2005 to aid efficient and thorough literature searching. PICO represents:

Patient or Population

Intervention

Comparator or Control

Outcome

To answer the research question, the format explored the following terms which were then linked with appropriate Boolean operators to widen and focus the search when and where necessary.

1. Patients (subject (P))
2. Expectations (Feelings and beliefs (I))
3. Therapist, Treatment and other Objects (O))

The search started wide, and then focussed on specifics. For Population this is treatment – naïve patients, and explored modifiers such as age, culture, ethnicity, third-party funding, and obesity.

For Expectations, this explored a wide range of attitudes and assumptions

For Outcomes, this explored the whole range of areas within practice, from the therapist, to the final outcome.

Search strategy

A bibliographic framework was plotted to guide the literature search. Methodological and topic literature was searched; a list of key words and phrases was created to search the library online public access catalogue (OPAC) to identify authors who have produced work within the area of expectations in healthcare globally and concerning osteopathy specifically.

An initial basic search was carried out using a second generation search engine e.g. (Google) and a meta-search engine (metacrawler) using the combination patient + expectation. Data sources accessed also included electronic databases for published research including PubMed, Allied and Complementary Medicine Database (AMED), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Science Direct, Ingenta Connect, British Nursing Index(BNI) , PsychLit, System for Information on Grey Literature (SIGLE), Sport discus, the Cochrane Collaboration, EMBASE, Physiotherapy Evidence Database (PEDro), Public Library of Science (PLoS), the Vienne School of Osteopathy, OSTMED, Social Science Citation Index, Department of Health , Google Scholar, and the Index to Theses. Databases to identify research in progress (the National Research Register and charities associated with health insurers including AVIVA (formerly AXA PPP), and BUPA were also searched. The NCOR database of unpublished research was also searched.

Search terms were identified using thesaurus terms to locate synonyms; Medical Subject Headings (MeSH) were also employed in addition to key words from located papers. BOOLEAN operators were used with search terms to form search strings and to narrow the search where appropriate. Citation indexes via the Institute for Scientific Information (ISI) were used to locate publications that have cited particular authors; key authors included Kravitz, Baker and Barron. Articles were then searched within journals both online versions within a variety of databases and hard copies of older journals (e.g. the British Osteopathic Journal) stored on library shelves (particularly at Osteopathic Educational Institutions). Pearl citation searching was also employed to expand the possible literature sources.

A number of healthcare disciplines were searched within the bibliographic framework shown overleaf.

Specific search terms were used with aids to expand the extent of the words used. Aids include [ti] = Title. The abbreviation "*" extended terms to include all variations e.g. osteopath with locate osteopath, osteopathic and osteopathically; the term "?" located terms that can be spelled with either an "s" or a "z", with one letter missing when used in either UK or US contexts and can locate terms where hyphens may or may not be used. No language restrictions were employed as limits to the search.

The search terms used with their synonyms are recorded above.

Healthcare	**Education**	**Social science**	**Psychology**	**Information Science**	**Law**

Tools to search subject areas

Library catalogues	**Print sources**	**CD ROMs**	**Databases**	**Websites**
↓	↓	↓	↓	↓
General search OPACs	**subject specific abstracts**	**subject specific abstracts**	**subject specific abstracts**	**subject based organisations**

A search log was kept to record data sources accessed and results obtained.

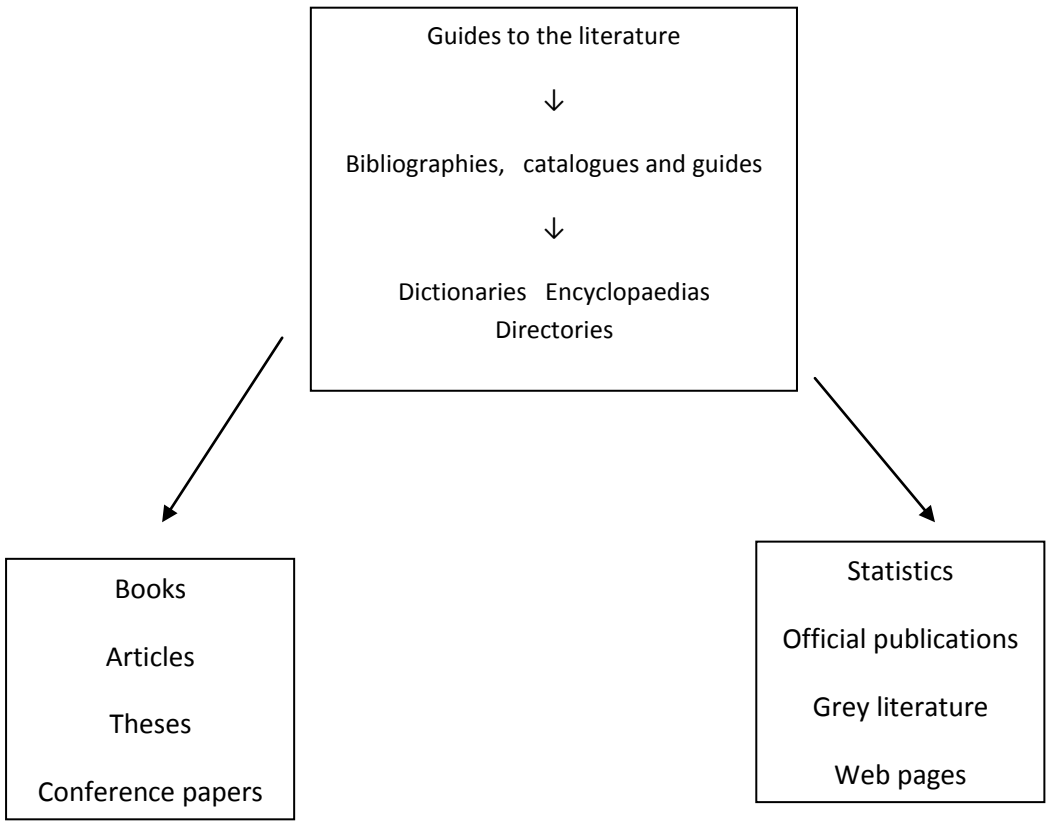


Figure 2. The bibliographic framework for the OPEN project search strategy.

Search terms included:

SYNONYMS 1	SYNONYMS 2	SYNONYMS 3
Patient	Expectations	Outcomes
case	Belief	Therap*, care
subject	Anticipation	Consultation
Client	Fear	professional*
Outpatient	Hope	Communicat*, interaction
sufferer	Motive	Therapeutic alliance*
	Presumption	Patient-practitioner partnership Physician-patient
	Confidence	Concordance
	Prospect	Adherence
SUBSETS "AND"	Trust	compliance
AND insurance	Satisfaction	consent
Age, elder*	Preference	Health?care
Paediatric* child* adolescent*	Needs	Organisation, service,
Gender, sex	Demands	Health person?el
Cultur*	Choices	Response, endpoint
Ethnic*	Group directions	Progress, fulfilment

disabilit	Consent	Improvement, benefit
Unemploy*		Cure
obesity		Treatment decisions, plan
		Cost, value
		Quality, quality assurance, governance
		SUBSETS
		Specific therapies eg musculoskeletal manual therap* Osteopathy Physiother* Chiropract* Primary care general pract* family practi?e physical therap*
		Questionnair* OutcomeNEAR measure
		Private healthcare, private practice
		CAM Complementary and alternative medicine

The number of hits for each database using the search terms provided are recorded in tabular form. Papers were screened for relevance and the number of relevant titles has also been recorded. Papers were included from the inception of a database to July 2009 where relevant.

Database	**Number of hits**	**Relevant hits (excluding duplications from other databases)**
Pub Med	3344	388
AMED, CINAHL, PsychLit, BNI, Sport Discus	7044	324
Ingenta Connect	305	125
PLoS	57	8
PEDro	45	5
EMBASE	201	22
Vienna School of Osteopathy	3	1
OSTMED	3	0
Index to Theses	25	3
The Cochrane Collaboration	25255	27
Social Science Citation Index	31	0
SIGLE	52	0
Department of Health	46	0
NCOR student abstracts	5	3
Google scholar	43100	205
TOTAL	**79191**	**1108**
Google initial basic search	3,740,000	

The quality of the papers identified varied considerably. A small number of studies could be classified as being of high quality, for example systematic reviews; a selection of randomised controlled trials was identified also. The vast majority of studies were surveys of varying quality; they represent the lower end of the hierarchy of research, as shown in Figure 3 overleaf.

MA = Meta-analysis

Figure 3. The Hierarchy of Research.

Appendix 4. Table of main papers used in the literature review

The key papers used in the literature review are tabulated here, grouped according to topic area:

(1) Context; (2) CAM; (3) Manual therapies; (4) Osteopathy; (5) Satisfaction; (6) Expectation

	AUTHORS	YEAR	SUBJECTS	METHODOLOGY	FINDINGS
1.	**Contextual papers**				
	Parsons S, Harding G, Breen A, Foster N, Pincus T, Underwood M	2007	113 articles	Systematic review	Clear communication and respect wanted by both practitioner and patient
2.	**CAM papers**				
	Vincent C, Furnham A	1996	250 patients	Questionnaire of acupuncturists, homeopaths and osteopaths	Most important reasons for seeking CAM: emphasis on treating whole person; more effective than orthodox medicine; enable pt to take a more active role in maintaining health; orthodox medicine not effective. Osteopathic pts least concerned by side effects of orthodox medicine and most influenced by availability
	Kersnik J	2000	1753 patients	Questionnaire of GP patients	Users of alternative medicine have a more active approach to managing their problems
	Sirois F, Gick L	2002	204 patients	Questionnaire of CAM users and GP patients	Three components to CAM use: predisposing, enabling and need factors

Sirois F	2002	199 patients	Questionnaire of GP and CAM patients	CAM users treat their health issues at higher rate than OM patients; have a greater number of health problems; have more experience of CAM
Furnham A, Vincent C, Wood R	1995	256 patients	Questionnaire of users of GP, osteopath, acupuncturist or homeopath	CAM users are not homogeneous
Furnham A, Kirkcaldy, B	1996	202 patients	Questionnaire of OM and CAM users	CAM users may use more as result of deep held belief in effectiveness of CAM rather than disenchantment with OM
Lazar J, O'Connor	1997		Paper	Factors prompting use (and therefore giving insight into expectations?) include philosophy and active involvement
Richardson J	2004	237 patients	Questionnaire of NHS CAM clinic (osteopathy, acupuncture, homeopathy)	Seven distinct themes: symptom relief, therapeutic/holistic approach, improve quality of life, provision of information, reduction of risk of OM treatments, need for self-help advice and accessibility of such treatments on NHS
Dominicus W	2002	62 patients	Interview study of acupuncture patients	Patients reported goal attainment
Thompson E, Dahr J, Susan M, Barron S	2007	130 patients or parents of patients	Questionnaire of patients of homeopathic hospital	Expectations were symptom improvement (87%), reduce medication (21%), stop medication (15%)
Eustachi A, Pajtler H, Linde K, Melchart D, Weidenhammer W	2009	156 patients	Questionnaire of patients of hospital oncology dept	Expectations of CAM use included improved quality of life (48.1%), boosting immune system (40.9%), relief of side effects (37%) and symptom relief (26.6%)
Bishop F, Lewith G, Yarley L, Cooper C, Little P	2008		Questionnaire study	Ongoing project on acupuncture for Low Back Pain
Paterson C			Presentation	Desire for holistic approach one reason for seeking acupuncture

Ritvo P, Irvine J, Katz J, Mathew A, Sacamano J, Shaw B	1999		Paper	Cognitive model for patient motivation in seeking treatment
Paterson C, Britten N	2008	Review of 5 longitudinal interview studies using a constant comparative method	Review paper	Relief, being treated as a whole person
Linde K, Witt C, Streng A, Weidenhammer W, Wagenpfeil S, Brinkhaus B, Willich S, Melchart D	2007	864	4 RCTs of acupuncture patients	An improvement in symptoms (all 4 RCTs). Only questioning re symptoms but clear majority expected 'clear improvement' rather than 'cure'. None expected 'no improvement'
Turner R, Leach J, Robinson D	2007	219	Survey	Primary importance attached to telephone manner, practitioner's appearance and explanatory literature in patient confirdence.67% prefer practitioner to wear white coat
Ong C, Banks B	2003		Report	Primary reason cited for CAM use: more in control of healthcare, higher expectations of practitioner, helps relieve, just like it, find it relaxing. Re expectations, control or cure of symptoms is key. Primarily want to control, manage and prevent deterioration
Manual Therapy papers				
Szybek K, Gard G, Linden J	2000		Paper	The physiotherapist-patient relationship: applying a psychotherapy model
Potter M, Gordon S, Hamer P	2003	26 patients	Focus group study exploring treatment experience	Primary importance of communication

Sigrell H	2002	30 chiropractors, 336 patients	Survey	Expectations of treatment: to feel better (93.1% agree), to explain the problem (93.2%), to find the problem (89.9%), to give advice and exercise(88.4%), to be free of symptoms (67%). Pts potentially have lower expectations than practitioners. More important to pts that they are given advice and exercise. Pts expect to get better very quickly of have no opinion
Sigrell H	2001	Testing of 5 questionnaires for validity in patients with low back pain	Questionnaire design	Most common expectations: symptom free, problem will be found, to be given advice and exercises, to feel better, no expectations, won't be any help. These findings fed into second study. All 5 studies indicate patients' main expectations are an accurate diagnosis, an explanation and treatment with a positive outcome
Yardley L, Sharples K, Beech S, Lewith G	2009	14 patients	Interview study	High expectations of chiropractic in terms of speed of symptom resolution; some anxiety re treatment techniques
Myers S, Phillips R, Davis R, Cherkin D, Legadza A, Kaptchuk T, Hrbek A, Buring J, Post D, Connelly M, Eisenberg D	2007	444 patients with LBP	Questionnaire design	Higher expectations of recovery associated with greater functional improvement
Verbeek J, Sengers M, Riemens L, Haafkens J	2004	12 qualitative, 8 quantitative studies	Systematic review	Qualitative studies show two primary expectations are to know the cause of their pain (diagnosis) and for information or instruction. Pain relief comes up in many studies as an expectation as does a confidence-based association and good communication
Barron C, Klaber Moffett J, Potter M	2007		Opinion	Defines expectation. Link to satisfaction and outcome. Different types : ideal, predicted, normative, informed. Expectations are closely linked to health beliefs, self-efficacy, locus of control and attitudes

Kalauokalani D, Cherkin D, Sherman K, Koepsell T, Deyo R	2004	135 patients		Interview study and RCT	Strong association between patient expectation regarding benefit and treatment outcome. This association is treatment specific. General optimism id not an important influence
Rubinstein S, Knol D, Lebouef-Yde C, Koekkoek T, Pfeifle C, van Tulder M	2008	529 patients		Questionnaire study	Higher expectations that a treatment would be beneficial was one of several variables predictive of a favourable outcome
Hill J, Lewis M, Sim J, Hay E, Dziedzic K	2007	346 patients		RCT and questionnaire	Significant predictors of outcome included psychosocial, functional and demographic indicators
Underwood M, Harding G, Moffett J	2006		1259	RCT and questionnaire	Benefits of manual therapy and exercise in the treatment and management of back pain
Osteopathic papers					
Fricker A	2008		32	Undergraduate thesis; questionnaire study	Amongst unexpected aspects of the treatment that were not specific to college clinic were undress and range of techniques and interruptions
Fiske A	2004		11	Undergraduate thesis; interview study	Primary motivations: specialists, manual treatment, effective. V scant knowledge of what osteopathy may involve
Strutt R. Shaw Q, Leach J	2008		181	Questionnaire and focus group study	Reveals that themes of hope (symptom relief, transformation, allaying fears and regaining control of life), communication, trust and respect are fundamental to the therapeutic relationship
Westmoreland J, Williams n, Wilkinson C, Wood F, Westmoreland A	2006	20 patient		Questionnaire and interview	Strengths and limitations of GP care and osteopathic care
Monro M	2001	140; osteopaths and patients		Questionnaire study	Primary aspect of care for patients is reducing symptoms. Most important category of care

Fulda K, Slicho T, Stoll S	2007		30	Questionnaire	Sub therapeutic ultrasound a better placebo than light touch
Williams N	2007	12 RCTs		Systematic review of RCTs	Psychological benefits to spinal manipulation explored
Vieder J, Krafchick M, Kovach A, Galluzzi K	2002		160	Questionnaires, focus groups	Elderly prefer direct verbal communication
Kane M	1995			Opinion	Research methods into patient perspective need to take account of the personal significance of illness and treatment
Fawkes C		440		Questionnaire survey	High levels of satisfaction particularly where associated with good communication skills
Patient satisfaction					
Thompson, Sunol	1995			Review article	Review of definitions of expectations, and illustration of models linking expectation and satisfaction
Jackson J, Chamberlin J, Kroenke K	2001	500 patients being seen by 38 participating clinicians		Pre- and post-visit surveys of patient satisfaction	Survey assesses patient symptoms characteristics, symptom-related expectations, functional status, mental disorders, symptoms resolution, unmet expectations and satisfaction. A lack of unmet expectations was a powerful predictor of patient satisfaction at post-visit surveys at 2 weeks and 3 months.
Spaeth GL	2006			Opinion	Unfulfilled expectations in post-surgical cataract patients led to dissatisfaction with all aspects of care. Controlling expectations may be more effective than improving post treatment outcomes in terms of maximising satisfaction
Peck BM, Ubel PA, Roter DL et al.	2004	253 male patients in a veterans general clinic		Prospective cohort study	Patient-centred care requires clinicians to be aware of and responsive to patients' expectations. The study concluded that patients' expectations are varied and often vague, and clinicians must be prepared to elicit and address the multi-factored nature of expectations.

Peck BM, Asch DA, Goold SD et al.	2001	290 male patients attending a veterans general medicine clinic	Randomised controlled trial to determine the number of expectations identified by three different survey instruments	A short instrument surveyed expectations concerning tests, referrals, and new medications. A long survey instrument asked about the same factors in greater depth. The longer instrument elicited more expectations concerning tests, referrals and medication. Unmet expectations were more commonly identified by the long instrument.
Welsh J	2001	187 patients attending a hospital Accident and Emergency department	Questionnaire survey	Survey identified that the most common expectations were, in order of priority, treatment provision, assessment/examination, diagnosis, "help make it better", X-Ray, reassurance, explanation, and relief of pain.
Small N, Green J, Spink J et al.	2007	13 patients attending a community hospital	Qualitative interview study	Patients welcome a model of care incorporating a technical approach to rehabilitation delivered with a human approach. Patients' involvement in the decision-making process was preferred but this necessitated clear explanations for treatment rationale.
Features of expectation				
Berry H, Bloom B, Mace BEW, Hamilton EBD	1980	60	Crossover double-blind controlled trial	Expectation measured prior to admission to a clinical trial. Expectations of pain relief, freedom from side effects, depression relief, improved mobility, improved sleep and speed of action were compared pre- and post-admission to the trial. Relief of depression, improvement in sleep and lack of side effects were rated as more important than pain relief.
Agras WS, Horne M, Barr Taylor C	1982	30	Clinical trial	The effects of relaxation training on blood pressure lowering were measured between two groups one of whom was told to expect delayed blood pressure lowering, and the other an immediate effect. Expectations of delayed blood pressure lowering significantly affected results (17.0 mm mercury (Hg) lowering in the group expecting immediate effects and 2.4 mm Hg in the delayed effect group.
Holmes-Rovner M	2005		Editorial	Challenging the policy that increased patient choice will produce better informed patients whose demand for health services will decrease.
Henderson GE, Churchill LR, Davis AM et al.	2007		Review	Exploration of the phenomenon termed therapeutic misconception and its effect on outcome of both research trials and treatment

O'Connor AM, Pennie RA, Dales RE	2009	292 patients naïve to flu immunisation	Randomised controlled trial	Risk/benefit information concerning immunisation was framed either positively or negatively. The effect of this on expectations, and decisions and decisional conflict was surveyed. Framing was not found to influence patients' decisions in contrast to earlier work on framing. This was thought to be due to the high levels of awareness concerning risks of complications from influenza vaccinations.
Coulter A	2006		Editorial	Examines modern perceptions that expectations can lead to unrealistic and unreasonable effects of care. The beneficial effects of expectation on recovery and self efficacy are regarded as a corollary to negative view points.
Shim JK, Russ AJ, Kaufman SR	2007		Retrospective patient accounts and interviews with family carers and clinicians	Patients do not distinguish between clinical promise and clinical possibility. Patients expect the best case scenario and assess post treatment living in accordance with such expectation.
Dixon M	2006		Opinion	Discussion of means to promote the fulfilment of patient expectations and satisfaction through provision of cost efficient services, increasing capacity and local public involvement.
Delgado A, Lopez-Fernandez LA, Luna J de D, Jimenez M, Gil N, Puga A	2008	360 patients consulting their GPs	Questionnaire survey	Validation of a 13 item scale of patient expectation when seeking advice for health problems. Expectations were identified as being multi-factorial and not homogenous in different clinical settings.
Edwards M	2008	Single 26 year old female patient	Significant event review	Discussion of the conflict between professionals acting in terms of goof clinical governance and sensitive situations not meeting patients' expectations and becoming a cause of complaint
Keitz SA, Stechuchak KM, Grambow SC, Koropchak CM, Tulsky JA	2007	211 patients in a primary care setting	Observational study	Pre-visit expectations, post-visit fulfilment of expectations, satisfaction and trust were determined from survey data. These factors were explored through recorded interviews. Most expectations were met; physician behaviour was altered 50% of the time based on expectations. Expectations for tests and medication were met more frequently than for referrals. Patient satisfaction and trust remained high regardless of whether expectations were met.
Coulter A	2004		Editorial	Exploration of the governmental drive for "fully engaged patients" involved in decision-making related to their care. This approach is advocated to offer the most cost-effective means of matching demand

				and supply within a context of wider choice and changing expectations within healthcare.
McCarthy CJ, Oldham JA	2005	95 patients	Three stage design involving focus groups, a Delphi consensus questionnaire, and a survey	Certain aspects of service provision are rated more highly than others. Differences in the strength of association were noted between the constructs of patient satisfaction and meeting patients' expectations of service, and were specific to individual service.
Kvaren C, Johansson E	2004	74 subjects from Sweden, Iran and Iraq	Survey	Assessment of pain using McGill short form and Magolis pain drawing and scoring system. The study confirmed earlier work that cultural differences exist in the pain experience.
McIntosh A, Shaw CFM	2002	GPs (N=15) and patients with low back pain (N=37)	Qualitative study	Barriers exist to patient information provision both in general and specifically for back pain. The barriers need to be addressed to close the gap between strategy and implementation. Contradiction in information leads patients to search for information from other sources which, in turn, leads to unreasonable expectations.
Kapoor S, Shaw WS, Pransky G et al.	2006	300 patients absent from work	Questionnaire survey	Comparing patient and provider expectations of return to work after occurrence of low back pain. Patients may form negative expectations for return to work even before treatment and this is associated with longer duration of absence from work.
Wetzels R, Harmsen M, Van Weel C et al.	2009	433 patients in primary care	Cochrane review	Three studies were examined in the review which looked at the influence of pre-visit information booklet and pre-visit information session and its influence on the involvement of older people in primary care episodes.
Hyer L and Collins J	1986	5347 patients of various ages (N=4361 young and N=986 older) after hospital discharge	Survey	Treatment expectations were assessed and compared with adjustment after hospital discharge. Self-rating assessment identified treatment expectations increased with age and higher expectations of treatment lead to better adjustment after discharge. Differences between expectations of younger and older patients were most notable in psychotics and older patents not fully or currently employed.
British College of Osteopathic Medicine	2008	POstE study	Survey	Examining patients' experiences of osteopathic care – study on-going.
Hearn J, Higginson IJ	2000		Systematic review	Reviewing expectations in palliative care; satisfaction is described based on the basis of the expectation of symptom control, reduced numbers of days in hospital, and good communication for both patients and carers.

Calman K	1984	Cancer patients	Hypothesis	Exploring the factors, including expectations, that affect the quality of life of cancer patients.
Davies HTO, Nutley SM, Mannion R	2000		Discussion paper	Examination of the manner of organisation within healthcare environments impacts on the quality of healthcare. Exploration of key items that patients expect from such environments.
Melzer D, McWilliam B, Brayne C et al.	2000	Dementia patients, N= 10377	Survey assessing disability prevalence between different socioeconomic groups	Individuals associated with higher socioeconomic groups in England, especially men, can expect fewer years of disability despite longer overall life expectancy.
Koller M, Lorenz W, Wagner K et al.	2000	Cancer patients, N=55	Questionnaire examining expectation and global quality of life measured	The expectation of healing in cancer patients is a component of good global quality of life. Limited expectation in terms of pain control and tumour control relate to a lower quality of life.
Rutishauser C, Esslinger A, Bond L et al.	2003	Teenage students of varying ages (N=613)	Cross-sectional study using a 40 item questionnaire	A number of key expectations were identified in this age group including the ability to see a GP alone, short waiting times, confidentiality, and the opportunity to discuss nutrition, drugs ands sexuality.
Sebrell WH	1953	Speech		Reproduction of a speech highlighting the challenges of meeting patients' expectation s within the newly-created NHS
Lawrie J	1976		Correspondence	Discussion of attitudes between older doctors and patients and its impact on the working lives of women doctors in primary and secondary care.
Underwood M, Harding G, Klaber-Moffett J in collaboration with the BEAM trial team	2006	Patients with low back pain (N=1259) participating in the UK Back Pain Exercise and Manipulation (BEAM) trial	Questionnaire survey within an ongoing randomised controlled trial	Exploration of patients' perceptions of participating in a randomised controlled trial and their views on the treatment packages received.
Jerant A, Levitch BT et al.	2005	Medical students (N=96) involved in managing patients with chronic care needs	Before and after study	Students participated in workshops, lectures, and role play involving performing self-care tasks. The impact of the workshops and other interventions on their knowledge of the needs of chronic care patients was assessed. The intervention was found to increase their knowledge, and improve their expectations and attitudes to chronic care patients.

Wiles R, Cott C, Gibson BE			Narrative synthesis	Examination of the effect of hope and expectation on recovery from illness.
Rowbotham MC	1953		Opinion piece	Article concerning the centralisation of services at Faulkner hospital and the effect of efficiency and patient satisfaction
Andreassen H, Harving B, Drensgård G	1974		Article	Discussion of patient's expectations of nursing staff in Denmark
Noyes RW, Levy MI, Chase CL, et al.	1974		Article	Discussion of the usefulness of using fulfilment of patients' expectations as a measure of patient satisfaction.
Staniszeska SHT	2007		PhD Thesis	Examination of the patient's evaluation of healthcare culture within the context of patient health status, expectations, and satisfaction.
Watkins CL	1999		PhD Thesis	Examining the effects of patients' expectations on their rehabilitation following a cerebro-vascular accident.
Smith J	1989		PhD Thesis	Examination of UK outpatient services in UK hospitals and how this meets the expectations of both patients and doctors.
Williams S, Weinman J, Dale J et al.	1995	504 patients attending GP (N=25) in London practices (N=10)	Questionnaire survey	The Patients Intentions Questionnaire was administered prior to seeing the GP, and the expectations met questionnaire (EMQ) was administered after consultation. Satisfaction with the consultation was measured using the Medical Interview Satisfaction Scale (MISS). Most patients wanted an explanation of the problem; fewer expectations were found for tests, support or diagnosis. Greater meeting of patients' expectations produced higher levels of satisfaction.
Cedraschi C, Fischer W, Goerg D et al.	1996	71 patients with low back pain were interviewed with their chiropractors (N=6) and rheumatologists (N=6)	Semi-structured interviews at the beginning and end of treatment	The role of congruence between patient and therapist in the perception of the evolution of low back pain and expectations about the future of back pain problems was examined. Congruence reflects an agreement about the management of a long term problem, rather than cure of a short term condition. Congruent patients accepted living with their back problems, in contrast to non-congruent patients who did not share the same view of their back pain.
Lurie JD, Berven SH, Gibson-Chambers J et al.	2008	740 patients with lumbar intervertebral disc herniation	Prospective observational cohort using patients in the Spine Patients Outcome Research Trial (SPORT)	Data concerning patient preference and expectation of treatment were gathered for this cohort of patients. A total of 67% preferred surgery and 28% preferred non-operative treatment. Patients' expectations of non-operative care was the strongest predictor of preference.

				Demographic, functional status, and prior treatment experience also had strong association with patients' expectations.
Johnson SM, Bordinant D	1998		Opinion piece	Authors discuss the factors affecting the osteopathic profession in the USA and how this reflects on their professional identity.
Miller K	1998		Case analysis	Tracing the development of the osteopathic profession in the USA and how it has forged a professional identity. The influence of the social environment on the changing nature of the profession is also considered.
Laird SD, McNabb JE, Coon SA	2005		Discussion piece	The authors discuss the helpfulness of using mentorship to develop professionalism in osteopathic students in the USA.
Fresa-Dillon KL, Cuzzolino RG, Veit KJ	2004		Discussion piece	The role of orientation exercises in the curriculum and its effect on professionalism is discussed.
Aguwa MI, Liechty DK	1999		Discussion piece	Examining the professional identity among a cohort of osteopathic graduates from 1992
Baer HA	1984		Article	Tracing the development of osteopathy in the UK and the move towards greater recognition within UK healthcare.
Savage LM, Ramos RL	2009	Animal study	Laboratory research	This animal study suggests that Pavlovian-induced reward expectancies can change both behavioural and brain processes.
Bubic A, von Crampon Y, Jacobsen T et al.	2009		Experimental study	An increase in activity in the pre-motor and cerebellar components of the standard setting sequences occurs due to detection of sequential deviants. This pattern of activity reflects the detection of a mismatch between the expected and presented stimuli.
De Hempetinne C, Lefèvre P, Missal M	2008	Animal study	Laboratory research	The neuronal basis of expectation is poorly understood. Rhesus monkeys were trained in a smooth pursuit task indicated by the direction of a colour cue. Neuronal activity increased after presentation of a cue in an expected direction; activity either remained unaltered or reduced if an unexpected direction was cued.
Labus JS, Naliboff BN, Fallon J et al.	2008	46 patients (24 female and 22 male) with irritable bowel syndrome	Laboratory based research measuring brain responses to aversive visceral stimuli.	Sex-related differences were noted in brain response and were found to be largely due to alterations in the effective connectivity of emotional-arousal circuitry rather than visceral afferent processing circuits.

Bell RA, Kravitz RL, Thom D et al.	2002	909 patients attending physicians in 45 practices in USA	Questionnaire survey administered before and after outpatient visits	Unmet expectations adversely affected patients and physicians alike. Failure to fulfil patients' requests played a significant role in patients' beliefs that physicians did not meet their expectations of care.
Cooke T, Watt D, Wertzler W et al.	2006	941 patients in an emergency department	Cross-sectional telephone survey visiting the emergency department in 2002 in Canada	Patients placed the highest importance on the explanation of test results, a description of any condition that would require a return visit to the department, explanation in jargon-free language, and the reason for any tests. Variation in waiting time depending on severity of symptoms was expected as was regular updating on the time to access to care.
Buetow SA	1995		Discussion paper	The authors provide a framework for answering key questions relating to what patients and their GPs require from general practice.
Fassaert T, van Dunelm S, Schellevis F et al.	2008	524 consultations between Dutch GPs and their patients	Videotaped consultations and completion of outcome measures by patients. Outcome measures included state anxiety (STAI), functional health status (COOP/WONCA charts), and medication adherence (MAQ).	Inducing positive patient expectations was helpful when delivered through reassurance and clear communication of a problem and its anticipated sequelae. The importance of paying attention to the patient's mood and tailoring a communication strategy accordingly was also emphasised.
O'Connor SJ, Trinh HQ, Shewchuk RM	2000	292 patients and 1702 nursing and medical personnel	Cross-sectional study using the 22 item SERVQUAL scale to measure patients' expectations for service quality and medical and nursing staff understanding of this feature.	Medical and nursing personnel underestimated patients' expectations for reliability, assurance, responsiveness and empathy. The students demonstrated the poorest understanding of the need for service reliability.
Hills R, Kitchen S	2007		Literature review	Review of patient satisfaction literature and the creation of a theory of satisfaction based on the concepts of needs and expectations.
Janzen AM, Silvius J, Jacobs S et al.	2005		Literature review	Synthesis of the literature and development of a conceptual model based on patients with newly diagnosed Alzheimer's disease.
Graz B, Wietlisbach V, Porchet F et al.	2005	197 patients with low back pain and/or sciatica	Prospective study with patient and physician questionnaire.	More optimistic physician expectation was associated with better improvement of psychological dimensions in patients who received treatment not meeting explicit criteria of appropriateness. The concept of the curabo effect is also discussed.
	1998	Patients with either low back pain or neck pain	Randomised controlled trial	Patients' expectations of treatment and wellbeing were important in terms of the prediction of outcome. The number of pain sites was also

		attending receiving either physiotherapy (N=144) or chiropractic (N=179) in Sweden		found to be an important factor in prediction of outcome. This has previously been shown to have a detrimental effect on outcome.
Toyone T, Tanaka T, Kato D et al.	2005	Patients undergoing discectomy for lumbar disc herniation (N=49), and patients who underwent laminotomy for spinal stenosis (N=49).	Prospective consecutive series	Positive expectations were met with higher satisfaction in both groups of patients. Even meeting clinical expectations did not always meet with high levels of satisfaction. Patients with spinal stenosis had the more unrealistic expectations of the outcome of surgery.
Grimmer K, Sheppard L, Pitt M et al.	1999	Physiotherapists (N=74), physiotherapy patients (N=121), general practitioners (N=21), and third party payers (N=13) of a total of 16 available insurers.	Observational design using interviews and questionnaires	Naïve patients expected symptom relief at the end of the first treatment and in some instances decided to return for further appointments for advice based on their relationship with the therapist. Experienced patients expected both symptomatic relief and advice within the same treatment. Physiotherapists and insurers expected provision of symptomatic relief and management strategies. Third party payers expected cost-efficient management of the symptoms and patient satisfaction.
Carr AJ, Gibson B, Robinson PG	2001		Discussion paper	Consensus process to develop a model of quality of life placed in the context of expectation and experience
Heymans MW, de Wet HCW, Knol DL et al.	2006	299 low back pain patients	Secondary analysis of data	Factors concerning the beliefs and expectations of the workers affected the return work process. The factors identified included self-predicted timing of return to work, pain intensity, job satisfaction, social support, pain radiation, and expectation of treatment success of the occupational physicians.
May S	2007	34 patients with back pain	Qualitative study using semi-structured interviews	Thirteen key themes emerged; 7 related to issues of patient satisfaction; 6 related to patients' experience and attitudes to back pain and its management. A common finding was the degree of acceptance concerning the presence of the back pain and the belief that patients' involvement in its management was key to producing a favourable outcome.
George SV	2005	66 patients with low back pain.	Inception cohort	Identification and use of a questionnaire that could distinguish between patients' satisfaction and expectations with treatment effect and treatment delivered.
Hills R, Kitchen S	2007		Literature review	Examination of the literature to forma conceptual model for patient satisfaction with physiotherapy.

Hills R, Kitchen S	2007	420 patients with acute and chronic musculoskeletal conditions	Survey using a 38 item self-completion questionnaire	Patients were generally satisfied with interpersonal, technical and organisational aspects of care. Lower levels of satisfaction with care were present in both groups.
Doyle C, Crump M, Pintile M et al.	2001		Cost study	Evaluation of the expectations, outcomes and costs experienced by patients receiving chemotherapy for advanced ovarian cancer.
Spinhoven P, ter Kuile MM	2000	169 patients with chronic tension type headache	Randomised controlled trial involving either self-hypnosis or autogenic training	Investigation of whether hypnotic susceptibility predicts post-treatment pain reduction, and persistence of pain reduction during the follow up treatment phase. Pain reduction was associated with hypnotic susceptibility and was independent of generic expectations of treatment outcome.
Belle Brown J, Sangster LM, Østbye T et al.	2002	Focus groups involving 9 physicians in either family practice, emergency medicine, or walk-in clinics	Qualitative study using audio-taped focus groups	The growth of walk-in clinics in Ontario's health care system was attributed to an increase in patients' expectations for convenient health care and a perceived decrease in availability of family practice physicians.
Goldstein MS, Morgenstern H, Hurwitz EL et al.	2002	681 patients undergoing chiropractic treatment for low back pain	Randomised clinical trial	Initial treatment confidence for low back pain varies according to the type of care. Higher confidence can have beneficial effects on outcome. Other predictive factors included being older, having acute pain, and being non-white (sic).
Thompson K, Parahoo K, Farrell B	2004	4466 contacting the out of hours service at two out-of-hours cooperatives in Northern Ireland	Postal questionnaire survey	Patients with realistic expectations were more likely to have those expectations fulfilled. The study concluded that the population should be made more aware of the availability of the out of hours services provided by cooperatives to ensure expectations were realistic.
Iles RA, Davidson M, Taylor NF et al.	2009		Systematic review	Recovery expectations can identify patients at risk of poor outcome with non-specific low back pain when measured using a specific time-based measure within the first 3 week of onset.
Mangione-Smith R, McGlynn EA, Elliott MN et al.	1999	Physicians (N=10) and patients attending for sick visits with their children (N=306) in one community based and one university based practice	Pre-and post-visit survey to explore the expectations and their fulfilment on antimicrobial prescribing behaviour	Physicians' perceptions of parents' expectations of antimicrobial prescribing was the only significant factor in their prescription. Physician antimicrobial prescribing behaviour was not associated with actual parental expectation underling the need for more effective communication to avoid unnecessary antibiotic resistance.

Tsao JCI, Meldrum M, Bursch B et al.	2005	45 children and 39 parents attending for complementary and alternative medicine (CAM) interventions in a paediatric chronic pain clinic.	Survey comparing the ratings among parents and children of expected benefits of CAM	Children expected the benefits of CAM to be fairly low when compared to their parents who were only somewhat more positive. Surgery was viewed as the least helpful intervention by both parents and children.
Perlman AI, Eisenberg DM, Panush RS	2005		Survey among rheumatologists	The need for rheumatologists to become better informed and more comfortable when talking with their patients about the use of CAM therapies was advocated. This will assist patients in making an informed decision about their most suitable treatment and management strategy.
Van der Weijden T, van Velsen M, Dinant G-J et al.	2003	567 doctor-patient consultations involving 21 Dutch GPs	Observational cross-sectional study examining GPs test-ordering behaviour when faced with unexplained complaints	Patients' expectations of tests influenced test-ordering procedures. Guideline development in this area would assist GPs.
Fulbrook S	2008		Discussion paper	Contextualising expectations by correlating the legal definition of expectations and how they underpin the understanding of standards of care and behaviour expected of professionals. This is contrasted with political expectations advocated by Government.
Wilson-Barnett J	1989		Discussion paper	Exploration of the limitations of solely using the principles of autonomy and self-determination to underpin current thinking on relationships in healthcare
Berghofer G, Lang A, Henkel H et al.	2001	420 naive and returning patients in psychiatric inpatient and outpatient settings	Survey	Patient satisfaction was related to treatment expectations in both naïve and returning patients.
Bower P, Roland M, Mead N	2003	General practice patients	Secondary analysis of general practice research data examining patients' views on access to primary care.	Patients' expectations of access to primary care may be in excess of government targets. Patients also have high expectations of continuity of care in primary care.
Himmel W, Sculte M, Kochen MM	1993	71 GPs in Germany and 310 patients	Mixed method study involving a survey to GPs, and interviews with patients	There was a gap between doctors willingness and ability to use CAM and patients' demands for these alternative methods of treatment.

Meijer EM, Hugenholtz NIR, Sluiter JK et al.	2008	50 randomly selected patients sick listed due to upper extremity musculoskeletal disorders	Qualitative study involving face to face interviews (N=24) and telephone interviews (N=26) to identify patients' failure to start treatment for their symptoms	Most patients had no intrinsic expectations of treatment but felt they would be too psychologically based to help their symptoms.
Enthoven P, Skargren E, Carstensen J et al.	2006	Male (N=10) and female (N=30) patients with low back pain being treated in primary care	Quantitative follow up study	The independent predictive value of a number of factors for disability at 5-years post treatment was examined. Influencing factors in maintenance of symptoms included being female, presence of previous problems, exercise level prior to injury, pain frequency at baseline and disability after treatment emerged as predictive factors for disability at 5 years.
Wiles R, Cott C, Gibson BE	2008		Narrative synthesis of qualitative research	A lack of conceptual clarity in relation to hope as a want or expectation was identified. Distinguishing conceptually between hope as a want and hope as an expectation has potential value in improving healthcare practice and informing future investigations.
Thompson AGH	2007	44 patients attending GP practices in Northern Ireland	Qualitative examination of taxonomy involved in patient consultations	A taxonomy of patient-desired involvement could be derived through using a qualitative methodology.
Willgerodt MA	2003		Discussion article	The value of using focus group methodology to develop instruments sensitive to different ethnic groups is discussed. Strategies for conducting meaningful and successful focus groups with different ethnic groups are discussed.

Appendix 5. A brief history of the development of osteopathy in the UK and its relationship with the NHS

The growing professionalisation of the osteopathic profession in the UK has been well documented (Baer, 1984); this has also been well discussed in American literature (Johnson et al., 1998; Fresa-Dillon, 2004). Osteopathy in the UK followed a divergent path to that in America; osteopathy in the USA evolved into osteopathic medicine becoming part of the medical mainstream whereas osteopathy in the UK has, in comparison, been more marginalised. Nonetheless patients' expectations of osteopaths in each country remain high, although the expectations of UK osteopaths are less clearly defined since the majority of osteopaths have no medical background. American osteopaths have attempted to address this dilemma by emphasising the need for professionalisation during training (Fresa-Dillon et al., 2004; Miller, 1998; Baer, 1981). American osteopaths have managed to retain their professional identity as a profession that has a uniqueness quite separate to allopathic medicine, whilst remaining part of the medical enclave (Johnson et al., 1998; Laird et al., 2005; Reid, 2001; Aguwa et al., 1999). The growth of professionalism and its attendant organisational infrastructure increases patients' expectations of the care delivered.

The contemporary osteopathic profession in the UK, in common with other healthcare professions is far removed from the profession that was developed in the UK by Dr John Martin Littlejohn. Modern healthcare in its broadest sense has undergone considerable transformation since the genesis of the NHS in the 19th Century following the experiences of the First World War (WWI), to its eventual creation in 1948. The creation of the NHS appeared at a time when Britain regarded healthcare as the answer to deal with one of the "five giants" (want, disease, squalor, ignorance and idleness) that Beveridge declared should be abolished after WWI. The NHS was established on three basic principles including 100% financing by central taxation, access to care for all, and care to be free at the point of use. In the intervening years, the NHS has had to balance the competing demands of accommodating

political ideology and dogma, and the financial pressures brought by advances in techniques and the knowledge that expectation would always exceed capacity. Policy from successive governments has also impacted on the organisation and infrastructure of the modern NHS particularly when better management became a priority. The Cogwheel report in 1967 (HMSO, London) encouraged the involvement of clinicians and Hospital Activity Analysis was introduced to provide better patient-based information. This impetus for greater involvement of professional groups and the focus of more attention on the patients has progressed throughout the intervening years. Despite the best of intentions, the Black report, 1980 (DHSS, London) emphasised that inequalities in healthcare were still present, as indeed they are still today.

Restructuring continued into the 1990's with the introduction of District Health Authorities; this occurred at a time when patients were being treated in increasingly complex ways. The 1989 White Paper "Working for Patients" outlined future reforms in the NHS, notably the introduction of the internal market. This was the government's attempt to address the problems of growing waiting lists. One practical change resulting from this White Paper that benefited some osteopaths was the introduction of fundholding budgets allowing general practitioners to buy in services from their NHS Trusts or the private sector. This represented a considerable opportunity for some members of the profession to provide services which were largely well received by both patients (Pincus et al., 2000) and GPs alike (Aswani, 1994; Singer, 1993; Burns and Lyttleton, 1994). The need to be involved in clinical data collection, audit, and be accountable for outcomes of care to a large organisation with budget restrictions was a novel departure for many practising osteopaths. The fact that some GPs adopted this type of service led to accusations that the founding principle of free and fair access for all to treatment was being eroded. Fund holding was phased out with the arrival of a change of government in 1997.

The introduction of the internal market had, however, left its mark, and the new Labour government in a stark contrast to its founding political ideology, continued to involve the private sector in the provision of healthcare to facilitate patient choice and focus on patient-centred care. This vision was encapsulated in the NHS Plan (Department of Health, 2000). More recent developments in the NHS have focussed once again on the role of quality in

healthcare. The Darzi review, 2008 and its emphasis on patient choice and quality of care have been more recently followed by the QIPP agenda addressing Quality Innovation Productivity and Prevention (NHS Institute, 2009).

The development of the NHS is in stark contrast to the development of osteopathic care. The profession has always prided itself on being patient-centred without the need for governmental prompting. The fact that osteopaths view patients as a single functioning organism rather than divided into specific systems which are managed in a piecemeal fashion is also in contrast with modern healthcare. Osteopaths have valued their independence of practice and protected this fiercely; many in the profession remain antagonistic towards the development of the regulatory process, the perceived notion of control and the ensuing restrictions of practise they fear this will bring. Regulation and the growing acceptance of osteopathy within mainstream healthcare is seen by many as being a double-edged sword, although it must be stated that many of the fears frequently voiced have yet to manifest.

Appendix 6. Themes derived in the qualitative analysis with illustrative quotes

THEMES AND CATEGORIES DERIVED FROM FOCUS GROUPS AND INTERVIEWS WITH ILLUSTRATIVE EXTRACTS FROM TRANSCRIPT DATA

THEME 1: INDIVIDUAL AGENCY

Coded extracts:

CATEGORY 1i: **Take control**

"It was my last thing. I was just, you know, someone's got to do something."

"I came out feeling relieved that I had found someone professional, who knew what to do, instead of just saying, 'Lie flat'."

"Empowered me I suppose, because then I knew more of what was going on, even though there wasn't a great deal I could do about it."

"You do something about it and go and see the osteopath and ask them to deal with it, (but) if there's still a problem there, I would think of a different way to try and solve it."

I used to just carry on and carry on if I had some sort of knock or whatever and work through it in a period of time. I've got now to the point where I think yeah, let's go and find out quickly and just sort it out"

"I think from experience you tend to know if something is going wrong, you leave it two or three days and if it hasn't gone back, you think well OK I've got to visit here."

"..because you… whereas you would leave it like you said, you know that it's not going to go away until you sort it out."

"If I was going somewhere else, I would try and find out what techniques they were expecting to use and sort of try to make sure that I'm going to be happy with the type of osteopathy I was going to get".

CATEGORY 1ii: **Need to know**

"…on the first visit they will understand what their problem is."

"Not only that but to find out why you've pain."

"…you need someone to actually assess it correctly."

"That's what you need. You need something to stop you worrying don't you?"

"He said, 'This is what I'm going to do because this is what I think it is, and then, in a couple of weeks if we're not getting the right sort of responses, then we're going to think about something else'."

"An osteopath can actually sit and explain to you what's going on…because that's what you're paying them for."

CATEGORY 1iii: **Financial sacrifice**

"It's over half my wages, but it's like I said to him, if I've got to pay that every week, or every other week, for the rest of my life, to feel how I'm feeling now..."

"But I think it's going to be an ongoing thing, and I don't care if it's going to be £85 a week."

"We got to stage when I just thought well you know, everything's going to go by the wayside, the shopping's just going to have to be cut down, you know, and things like that, to try and cut everything down, so I can see him because there's no way I could have coped any longer."

"That's the one thing that hurts me as much, if not more than the pain. It's the £38, because I can't afford it basically. My daughter's paying for it at the moment."

THEME 2: PROFESSIONAL EXPERTISE

CATEGORY 2i: **Specialist knowledge and skill**

"The bottom line that osteopathy does is pain relief. That's the bottom line. You don't go to an osteopath unless you have pain."

"Physios and doctors, they don't know enough about the actual knowledge-base skeletal, the muscles and things like that."

"…they learn skills to deal with each specific situation and…affecting joints and muscles."

"…these people can tell me about my body just from the fingers…whereas the hospital needs this big, fancy machines."

"…any kind of stiffness and soreness the osteopath will automatically be able to fix me."

"I think it all comes down to the skills of the individual."

"(He) used to speak about the flow of body fluids and generally talked sense."

"…he said the whole thing about it is draining away the toxins in your body…I think this is an old fashioned expression. I don't think the modern osteopaths talk like this now."

...because the spine moves, because he said to me when you put on weight... because I'm more flexible going back than I am going forward, when you lose weight you straighten up and that's why. And I said what? You know...I was thinking that's so simple!"
"Your balance, your centre of gravity changes."

CATEGORY 2ii: ***Open-minded approach***

"I think an osteopath would probably recommend other treatments, like referral to a doctor or what have you, but it's very rare your doctor will recommend an osteopath."

"Yes he's interested in, you know, whole body treatments, you know, all around the world is… talking about it the last time I saw him. He's being very open-minded to all sorts of avenues."

"…if it's not the osteopath's problem, they will speedily be directed elsewhere and that's the main thing that I'm looking for at the beginning, understanding."

"I do find with (Osteopath) particularly, he… he seems more than an osteopath, he knows… he seems to know a lot more about a lot more things than other osteopaths that I have been to in the past so… and if he can't tell you there and then, he will actually find out and make the effort to… well not effort, but he will call you back and let you know, so… I think that's nice."

"I was having some problems with my fingers and (Osteopath) wondered whether it could be linked, so he went away and looked it up to find out whether it could be. So he sort of just took it further than maybe he had to. He spent his own time looking it up …"

CATEGORY 2iii: ***Clear boundaries***

"So I think it's important that they check out with you, is that OK if I just put my hand there because I'm going to do such and such so that's… that's quite important I think, yeah."

"I think especially like as a woman."

I like some professionalism, so that you feel comfortable, certain boundaries, especially when you're being touched and sometimes you're maybe just in your underwear, that you've got to have that level of professionalism because people are in quite vulnerable positions and we get that where we go, so that's really good and that's important."

"Well you treat them... he treats you as a patient and you treat him as you would your GP don't you think? You know, you've got that sort of relationship between one another, he's a doctor...that's how you've got to think of him, you know."

"I expected him to be similar in his professional presentation to a GP."

"He treats you as a patient and you treat him as you would your GP…he's a doctor, that's how you've got to think of him".

"I seem to remember them saying 'Have you been before? ' (They told me) 'You'll be expected to go down to your underwear and it'll take about an hour', and they'll ask you quite a few questions, so I think they explain it over the phone…otherwise you walk in and all of a sudden they're right, down to your underwear and you think why? …it does put you more at ease which is nice. Not necessarily having it written down … but to have it explained to you first, before you initially walk in, instead of having it sort of sprung on you as …"

"Yes, you don't bother, you know, it's just a doctor, that's that… um… because of their… I suppose it's because…they are medical professionals, they are doctors in a different… in a different sense aren't they? You know, there… it… there's many, many doctors and I think they are looked on in a way like a doctor on a different…"

THEME 3: CUSTOMER EXPERIENCE

CATEGORY 3i: ***Building rapport***

"…they were great, really polite and accommodating. ..I actually had a chat, I think (the Osteopath) answered the phone so I was able to speak to him personally I think."

"... it's got to be smart… clean and tidy and a decent chair to sit in, maybe some magazines…you don't want luxury couches... just clean and tidy."

"God help us and save us all from doctors' receptionists…so I thank goodness that, you know, osteopaths have receptionists that aren't that bad."

"I find it very personal down there… it makes you feel like you're just not another number on their list…it's not like in and out.. you don't feel rushed when you go in there at all."

"I think if they'd carried on, maybe the NHS took more... went deeper into it and that... I'd have been better. Maybe someone like B, sort of earlier, um... but as I say well I could have started going back a long time ago if they'd said yeah do this... Um... I don't think they were quite um... experienced with dealing with people, as well, don't you think that's a lot to do with it because I used to go in and you say, where's your pain? Oh there. Oh right! Well now I talk about? Where does it come?"

"Yeah and they fit whatever you say in and um... when he's finished like, you know, it's not oh get up, get dressed, get out, he talks to you and says what's going to happen and how long, I think you ought to come back and he explains things and..."

"You're never treated as a body; you're treated as a person."

"Yeah, yeah, I mean when he's actually finished the manipulation, you get dressed and you talk to him then. It's not say- right, off the table, dress, bye-bye."

CATEGORY 3ii: ***Healing environment***

"I think they try to create an environment- - a healing environment. So that basically, you're going there in pain. You want to walk into somewhere that is going to feel relaxing and is comforting for your feelings before you go into your treatment."

"I think even when you walk through the door you feel relaxed…"

"I think you expect an osteopath to be a healer, first and foremost"

"A more holistic environment than a clinical doctor's surgery."

"It feels like I'm being loved back to health really, I can't believe how well I am when I leave here. I feel energised.

"I come with a confident expectation of being helped to be well."

"…the only way I can put it is that I am restored to myself again…somehow I'm part of humanity again."

CATEGORY 3iii: ***Accessibility***

"I think if you need to see him, he generally tries to fit you in and… I've never really had to wait that long in, you know… he will fit you in."

"…the number of people (in NHS)..if one goes over, the next one goes over and it builds up because they're so close, whereas in a private place like (Osteopath's) they do go over, but often if they've got someone not quite so drastic, the next patient, then they catch up with the time."

"You expect some flexibility if you're in severe pain. If it's a thing…you can live with it for a couple of days, yeah you don't mind saying 'I can wait a day or two', but when you've definitely done something either that day or quite recently and it's not getting any better, it seems to be getting worse, you... you'd like it the same day if you can."

"If you've got a problem, you phone up, they'll see you right away."
"(They are) freer to deal with patients as and when the help is needed, which is what…any sort of treatment of patients should be all about."

CATEGORY 3iv: ***Value for money***

"You actually pay for the service, you do expect, you know, that bit more than, you know, just your allotted 5 minutes, which is the way you feel about the National Health and understand it, you know, they're operating under very different pressures."

"I think it is because you're paying and it makes a difference, you're paying for a service, but you expect not only just your money's worth, but you expect everything else, the follow-up and the care that goes with that as well."

"That is customer service isn't it?"

"I would recommend an osteopath…that I consider to be competent, and not in it purely for money."

"He won't overstep, or take something on just because he's getting money for it."

"…and it was every week and …gradually, he's expanding the gaps between...He didn't say 'Come back next week', just for the sake of it."

I never feel pressured to make another appointment or like I'm being fleeced. He will say see how you go, you may not need to… to come back again. If you want to make an appointment for a couple of weeks, then you can always cancel it, you know, then you've got it as a sort of safety net, but just see how it goes, I would imagine you'll probably be OK now, and I don't feel any way that he's just…"

THEME 4: THERAPEUTIC PROCESS

CATEGORY 4i: ***Nature of intervention***

"I'm still not really 100% sure of the difference between a chiropractor and an osteopath. I think (osteopaths) don't do so much manipulation and so forth. It's more guiding, it tends to be a lot more rocking and pulling."
"…all the crunching business on the back, that took me by surprise…because I really didn't know they did that. I was expecting it all to be more massage-based rather than manipulation."

"I would expect to describe my problem, be examined visually, to be examined manually, and then manipulation to put back whatever's misplaced."

"(Friend) said it's rheumatoid arthritis that's your problem and it's things like osteoarthritis that the osteopaths do (but) I came to (the osteopath) and said 'Can you do anything?' Oh yes, certainly."

"Well what I expected… is manipulation and probably a good deal of relief on my first one."

"… just lay the hands on once and… finished, but we all know that you can't. I think it's a lot to do with the treatment as well is people realising that things take time, you cannot rush things like that."

"My experience was that it can be very sore, it can be very forceful during the procedure, and it can leave you very sore afterwards."

"She'd be gentle, but very firm…moves your limbs in a manipulative way, but it doesn't hurt at all, whereas he seemed to jerk you all over the place and I found it most uncomfortable."

CATEGORY 4ii: ***Impact on symptoms***

"For me…relief of pain and reasonable normal movement."

"…when you leave there you're going to be painful, tomorrow you might be a little stiff, but after that you'll feel a difference and it'll be better."

"…gauging the widening the gaps between the treatments, um... I think is part of the treatment because I think you... you can overdo it. I mean if you went every week, you don't know if you're getting better or not. …since he's been sort of widening the treatments I'm feeling better in between the treatments."

"No, it might take two or three visits, but as long as I understand it I know… if it takes… it's going to take time to go and sort something out, put something back in position or, you know, pushing you round the other way, then fine, OK it's going to take a little bit of time, but I think from the people I use they go and tell you that anyway."

CATEGORY 4iii: ***Session duration:***

"Yes, I think because um... as an individual dealing with appointments, he spreads the appointments so, say every half an hour, or whatever, so goes over a couple of minutes, um.... next patient might not take quite that long so it equals itself out, whereas you've got the NHS and all the rest of it and they're stacked every ten minutes."

"Well (Osteopath) gives you an hour on your initial appointment, for the same price as the usual standard treatment of half an hour, which I think is really good, because a lot of other people would charge you extra for that first initial consultation. But if he feels you need another five or ten minutes he'll do that… I think probably that's a nice enough slot really, most of the time."

"I think you'd be disappointed (not to get treatment) because you had gone there with some sort of expectation, somebody looking at you, because that's why you went there. If (history taking) took too long…he'd probably be very experienced in how to gauge… spacing an hour maybe for the first initial consultation…"

"That's why they take you for the hour I think… a full hour for your first consultation."

"And a session of half an hour or so, there is time to explain everything, which the doctor doesn't have time or even that intricacy of training."

CATEGORY 4iv: ***Ongoing maintenance***

"…and I'd rather go back say in six months if I had treatment, just, you know, just to make sure everything is right before it flares again and you're in that... that agony that is unbearable."

"(Osteopath) kept her going until she was 93…"

"We're coming once a week anyway, so we've sufficient aches and pains just to keep (going)."

"I feel it's worth coming once a week just to keep me going."

"I think once you've started, and you've got confidence, I think you'll want to go back, …just for a sort of check up every year or something like that."

CATEGORY 4v: ***Degree of involvement***

"I've always expected to be involved and he has always involved me. I've never been, 'I'll leave it to him'."

"It was his decision what he did, … but he was outlining a subsequent option if it didn't seem quite right."

"I expect to be listened to. When I first went there I thought they're just going to (say) 'This is wrong with you, that is wrong'. But (Osteopath) actually listens to what I've got to say about my body, because obviously I know it, and then he puts his professional opinion on it, because obviously he's trained to know these things. So he takes what I say on board and then explains it. And he tells me everything he's doing, so if I don't understand it I can ask him questions and he'll tell me. So I quite like that, and expect that from him."

"I don't really understand quite a lot of the stuff. I'll ask a question and I'll be like 'OK, well tell me a bit more about it.' So he tells me everything he's doing and how it's working and why it's working. I was quite pessimistic when I went, …if this is going to work, because I suppose I had the idea of a doctor helps you with your problems rather than an osteopath. So when I went I wasn't expecting (Osteopath) to explain every little thing to me and he did that, so that was really good, so I understood it all."

"So it's like you're involved…He explains that you understand and then he says, " If you don't understand, just ask". So normally I'm running over half an hour…"

"But I think is with him when he says that you don't feel silly asking because sometimes with people … you don't want to ask because you know they're going to think you're stupid. But … he will explain it again in another way perhaps that makes it more understandable."

"He talks to you first…because when you talk to somebody, what they say, you learn a lot from that. It's the way they say it, sort of interpret it in between.."

"If I have sufficient confidence in the osteopath, or whoever, then I don't expect that he would have to go into detail because that could take away from, you know, the confidence that the patient has in the osteopath, and that would be a bad thing."

"No. If I'm feeling bad on any particular day I come I tell them and I just expect him to get on with it and know what he's doing."

"I would certainly expect the osteopath to have a plan as to what he or she will do in a particular situation and just get on with it er… you know I'm going as a patient to him or her and, you know, and er… I mean he's very… the osteopath to tell me what to do and to go on with the appropriate treatment."

"I thought you're here, being paid to see what you can do to help me and you're instantly telling me what I've got to do for me. Now I don't disagree with the fact that yes I'll listen to what she says and go away and try and do my exercises as well to continue to help the treatment, but I thought it was a totally wrong opening."

"…and what will happen if you use the hot and cold and why… I mean my son bought me one of these heat massage things and I said to him I've been using that and he said yeah what about the cold? And I went ooh I don't want to put cold on. And he said no… and he explained why you need both, which was nice. I mean you just think heat is good for aches and pains, but then when someone says oh no icepack, you think yeah well OK."

"I think their remit as an osteopath is to treat people not to get you to treat yourself. You know, you're paying for treatment."

"I tried to get him to explain how things occurred as to, if it's in a strain or anything like that, if something else moved, how on earth… what on earth I did to go and cause it, and quite a few times it did used to come down to certain things I'd never dreamed it would come from. And he's very good at talking about golf as well!"

"… he involves you in the thought process…"

"it was better than what I expected, um... and I felt better from my experience and so this time it does hurt my neck and my shoulders, but I don't think that is all down to C, a lot of it is down to me, lifting suitcases and things and doing things I shouldn't have been doing, but that's me."

THEME 5: INTER-PERSONAL RELATIONSHIP

CATEGORY 5i: ***Being believed***

"But they don't always… people don't always believe you because there's nothing physical, they can't see anything…"

"Yeah, put up with the pain for years and years and years and... it's just to have somebody believe you really, because you can go to the doctor, oh I've go a pain here, I've got a pain there, oh have you? And as you say, pass out the tablets." 986-989 validation

"They put back problems or anything like that, and just one in for other. ??? You've got a back problem, oh everybody to some extent have got problems, and they don't seem to take it seriously, whereas you get a small percentage that have really got something wrong."

"And he doesn't judge you either…when I'm giving out my history and I'm thinking he must think… 'Haven't you got a list?' and he says 'Anything else now?' because he was running out of paper…… but he doesn't look down at you, you know."

"…and the shock of my father's sudden death, my mother was more or less crippled in three weeks and the doctors gave her eighteen months on her feet, so back she came to Mr. C and he kept going for a good number of years. Mr. A had said you know, a sudden shock could bring this back like this."

CATEGORY 5ii: ***Trusting relationship***

"I think you just trust him. If he says I'm going to try this, you trust him that that's the right thing, because you have complete faith in him."

"I haven't had any risks associated with my treatment, but I do feel confident that if there were any, he would say so."

"I think if you have a good osteopath there's nor risk whatsoever in what he does…when people say…'you could end up quadriplegic', I say 'Absolute rubbish!"

"I think you just trust him. If he says I'm going to try this, you trust him that that's the right thing, because you have complete faith in him. Having been going to been going to him for years and years, if he says that's what you need you believe him."

And he was like it really hurts and like was whinging about it, so it made me feel like well if it's hurting my dad, that's really going to hurt, so I was scared about all the pain and everything, but it was fine when I went and had it done though. It's like even when it does hurt he still makes you feel like it's OK, and it's over so quickly that it's OK, so yeah."

"I expect if there's any particular risk in one particular situation a patient ought to be told…but in practice, if the osteopath is fully in charge of the situation, and giving the proper treatment, I don't think there's any problem with anything."

"If I have sufficient confidence in the practitioner…then I don't expect he would have to go into detail (discussing risk) because that could take away the confidence the patient has.. and that would be a bad thing."

"…if the patient presents himself for treatment, well, there's implied consent."

CATEGORY 5iii: ***Sense of connection***

"…in the NHS I think because of the pressure...once you've done that course with them they don't want to know you."

"…you've got a more relaxed atmosphere…a connection between the two of you."

" I was having some problems with my fingers and (Osteopath) wondered whether it could be linked, so he went away and looked it up to find out whether it could be. So he sort of just took it further than maybe he had to. He spent his own time looking it up …"

"He cares that you've got an outcome."

"…as I say, you go to the NHS and you come to the end of your treatment or your allotted time for the treatment and (they say) 'Oh well it's wear and tear, don't know why, it's a bit of a mystery. If it keeps up go back to your GP'."

Appendix 7. Mapping topics for questions against GOsC Code of practice

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
1 - 2	Relationships with patients *Trust, putting patients first*	Form working relationship. Sense of connection. Sense of caring. To have trust and faith. Non-judgemental. Feel relaxed and at ease. Kindness and responsiveness. Sympathetic, Empathetic & Good bedside manner. Always treat my concerns seriously All practice staff to be polite and respectful at all times The osteopath to concentrate on my needs during the whole consultation Build confidence in patients in terms of facilitating questions and helping self-management Expect to see osteopath's qualifications Honesty	3, 9, 26, 28 15, 16, 18, 26 17, 18 4, 5, 9, 15, 40 17 18 17, 18 17, 18 31 15, 19, 20 14 34, 35, 36 7
3 - 7	Personal relationships with patients	Expect professional boundaries to be maintained	20
8	Undue influence on patients *Exploiting, pressure, gain*	I don't expect the osteopath to have a financial interest in selling me products I don't expect the osteopath to treat me more times than I need I expect at least 30 minutes of the osteopaths time for my money I expect to receive manual treatment even at the first visit	28, 37 13 21
9 - 11	Financial and commercial activities *Open and honest financial dealing*	EXPENDITURE Sacrifice Expect it to be expensive Expect choice in frequency of appointments Receive information beforehand about likely cost of treatment	 27
12 - 13	Insolvency		
14	Criminal convictions		
15	Civil proceedings		
16	Other professional bodies *(investigation by)*		
17 - 22	Communicating	PERSONAL INTERACTION	

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
	with patients *Information and expectations*	connection, trust, non-judgemental, communication Good communication skills Polite Accommodating Personalised contact Information on the expected after effects of treatment Information on the timescale for treatment length and numbers of treatment Expected to be listened to Explanation of examination findings Explanation of problem Explanation of treatment to be given and likely outcome To be kept informed as to what is being done and why Opportunity to ask questions Expect clear and sensible explanations Expect to be asked and to answer questions Explanation of manipulation and immediate after effects Warning and explanation about possible treatment soreness Explanation of possible time delay in feeling better To be given an explanation warning of hands on treatment Opportunity to call the practice for advice To be able to speak to a receptionist Need information about the necessity to remove clothes for examination and treatment purposes and to what extent Expected to be given information about gowns etc Patients attending student run clinics: Expect to be told there will be lots of examination within their treatment times, but not as much treatment and expected to be told that different students would be given them their treatment Expect to be empowered through information Expect courtesy Expect some formality Traditional approach To be given information before booking about the type of osteopathic techniques provided in the clinic To know what to expect when I went for the first time To be given very clear information during my first visit about what the osteopath is doing To be able to ask questions To feel free to discuss any concerns about the treatment or care The osteopath to give me the sort of information I understand The osteopath to be sensitive to how much information I want To be given information before your appointment To have the proposed treatment explained To be told how many appointments you will need To be told how much the treatment will cost	1, 2, 14, 15, 18 1, 24, 31 17, 18, 24, 25 17, 20 3 14, 27 4, 5 27 17 24, 25 24, 25 4, 5 4, 5 31 24, 25 16 2, 4, 5 5, 30 4, 5, 30 5 1, 19, 20 1, 20 1 19, 20, 31 1 1 2 3 31 25, 26 1 2 27 27

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
23 - 36	Consent	Don't expect to give consent No expectation of risk Consent is implied Expect to be told if there is a risk Expect to give consent To be asked whether you agree to the treatment protocol To sign a form giving consent To be told the probable benefits and any risks of treatment To be told if there are safer alternatives to the treatment proposed (?) The osteopath to ensure that consent for treatment of children is obtained from the is legal guardian, for example after parents of a child patient are divorced or if a friend brings the child Expect to be told about benefits of treatment	6 5 6 5 6 6 6 4, 5 4
37 - 44	Examining and treating intimate areas	Expect explanation of the need to undress beforehand ie; in advance of osteopathic consultation by phone Expect to be touched Expect to be told where hands will be placed and why Expect to be appropriately covered in terms of body parts and not exposed to others ie; those coming through a door in the clinic passing a cubicle Expect to be able to be allowed to undress in private area Expect the osteopath to keep to professional boundaries Expect that the osteopath to keep a distance especially in a male/female situation There is a need for patients to be told in advance about the need to undress for treatments and to what extent Expect warning before hands placed in a sensitive position or if bra needs to be undone Did not expect to feel so awkward when undressed to underwear Did not expect to be undressed for such a large part of the consultation	 21 21 19, 20 19 8
45 – 48	Patient modesty	To be asked to undress to your underwear for examination To be allowed to undress and dress in private To remain undressed during treatment To be given a gown or cover **Expect to see same osteopath** I feel embarrassed about undressing The osteopath does not put me at ease about being touched and pulled around	 19 20 9 19
49 – 52	Chaperones	If the osteopath is alone in the clinic, to ensure that the patient does not feel compromised (latest FG??) **Expect a chaperone**	 10
53 - 57	Patients rights in teaching or research		

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
58 - 61	Visual and audio recordings of patients		
62 - 68	The duty of care *Respect, equality*	The osteopath to discuss other options with me if I my symptoms are not improving I expect some compensation if my symptoms are made worse by treatment	
69 - 71	Your contact with the patient *Reasonable care*	Service delivery Open ended course of treatment Customer care Accessibility/flexibility/environment Opportunity for SOS/maintenance appointments Flexibility in timing and frequency of appointments Rapid access if necessary Same day treatment Disabled parking Disabled access Time to give explanation of the problem Time to be given an explanation of the treatment and expected outcomes Expect to have a treatment on the first visit One hour is adequate time for first treatment Treatment should be paced according to improvement Offer long term follow up For the patient to be involved in the treatment process and decision making Expect maintenance care eg; advice about exercise, physical activities, diet, lifestyle and general health Expect a specific treatment focus Expect to take part in the choice of treatment The osteopath needs to have a treatment plan Expect treatment on demand Expect the osteopath to be experienced and have relevant knowledge Expect to see the same osteopath on each occasion Don't expect a cure Expect education and advice on self-management Expect to be asked about reactions to previous treatments Expect answers to questions Expect to play an active part in the treatment Expect to provide information to the osteopath to help target treatment Expect to be asked about current medication Expect a patient focussed approach to care Expect an appointment within two days of request or within a week Expect to be given links to websites for appropriate information Expect not to feel rushed Would prefer treatment in a sound proofed area Expect a professional approach Expect holistic approach Expect to be involved in decision making Don't expect exercises	11, 12, 41 3 41 41 26 2, 27 3, 35, 36 9 34, 35, 36 32 31 16, 32 34 18 36 36 34, 35 34, 35 22 29

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
		Would like exercises Expect to self-manage / treat Don't expect to self-manage / treat Don't expect to be jerked around Expect it to hurt Expect different approaches from different osteopaths Expect specialist knowledge A hygienic practice Expected 2 or 3 treatments Did not expect electrical treatments Did not expect osteopath to treat more than one patient at a time Expect thoroughness Did not expect to be treated in a clinic with a sole practitioner and no other person present Expected to leave decision making to the osteopath *NOTE from JL – some of these may be better in 82)*	11 24 14
72	Home/domiciliary visits		
73 - 76	Relationships with colleagues	If I consult two different osteopaths about a problem, I expect them to come to the same diagnosis	
77 - 79	Relationships with GPs	Osteopaths will request x-rays via GP if appropriate Expect osteopaths to write to GP with information Don't expect GPs to approve of osteopathy I expect the osteopath and the GP to agree about the cause of my problem Expect cross-referral to other specialties as necessary	 33
80 - 81	Comments about colleagues		
82 - 83	Professional standards *Competence* *Clinical records* *Copies of records*	OSTEOPATH Professional approach/ Specialist expertise/ Open-minded Expect the osteopath to be trained to a certain standard Expect records to be kept Listening skills Up to date and knowledgeable Expect consistency between osteopaths CONSULTATION AND TREATMENT Outcome, session time, treatment pacing, followup To be asked about your problem/pain To be asked about previous medical history To be given a diagnosis To be told of any risks or side effects of treatment My main priority is concerned about pain relief	 16 16 25 5

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
		My main priority is to understand what is happening in my body disappointed not to see a big improvement in my symptoms after treatment I did not expect to increased pain the day after treatment I don't expect osteopathy to have side-effects like drugs The osteopath to recognise if I have any serious medical condition The osteopath to advise me to seek appropriate medical treatment for any serious medical problem The osteopath to promptly provide the records and documents I need for medical insurance claims	30, 38 5, 30
84 - 86	Personal standards *Fitness to practice*		
87 - 88	What the law requires		
89 - 90	The right to practise		
91	Professional indemnity insurance		
92 - 93	Legal limitations on what an osteopath can do *Limits to: Advertising, procedures, prescription, certificates, animal treatment*		
94 - 99	Complaints	The osteopath to have a complaints procedure in the practice If I make a complaint, I have an expectation of what the result should be	40
100 - 101	Problems with your health		
102 - 103	If trust breaks down		
104 - 109	The principles of confidentiality	I don't expect the osteopath to talk about my health problems if they meet me outside the clinic	15
110 - 115	Disclosures without consent		
116 - 119	Osteopathic records	Expect the osteopath to regularly up date personal records I expect the osteopath to want my full medical history	16
120	Data protection		
121	Access to records		
122 - 127	Practice information *accuracy*		
128	Fees	Expect an acceptable cost Expect value for money	28

Clause	Heading	Items from F.Gs NCOR3 patient complaints KGreen Questions Items from individual interviews	Corresponding question number
		Expect to make a financial sacrifice to pay for treatment Expect it to be expensive	
129	Your staff	Welcoming, Sociable *NB these clauses 129 and 130 relate to employment practice, not the patient interface – move to Clause 69?*	18 18
130	The work environment	Smart, clean tidy, comfortable waiting areas Welcoming attitude from receptionist staff Calm Receptionist Healing Don't expect loud-speaker announcements Expect easy access to treatment rooms Professional Friendly Formal Expect similar environment to NHS	11, 12
131	Disability discrimination Act 1995		17, 8
132	Race relations Act		
133 - 135	Health and safety		
136 - 141	Students and junior colleagues		
	Additional expectations of outcome	Expect pain relief, immediate or otherwise Expect to be manipulated Expect immediate relief of symptoms Expect reasonable return to normal movement Expect hands on treatment Expect sufficient treatment time ie; more than half an hour Expect to be able to have other treatments at the same time eg; physiotherapy, chiropractic Expect osteopaths to recognise if a patient is in pain during treatment Expect to see the same osteopath for consistency Expect individualised care Expect the osteopath to present rational thinking Expect a gentle approach Expect a cracking sound Expect the osteopath to refer to other health professionals as appropriate Expect treatment to be painful Expect to be told what to expect after treatment Never had any expectations Expect a prognosis Expect pain relief in one/two days Expect a choice in who will be seen Expect examination and treatment at first visit Expect to be massaged and not manipulated	 22 39 21 13 9 33 29
	No expectations		

Appendix 8. Table of the sources of questions used in the OPEn project questionnaire

	What I expect	Code of Practice	NCOR3	Kelly Green	Patient inter-views	Liter-ature review
1	I expect to be given information about what will happen during treatment before my first visit	-	Y	Y	Y	Y
2	I expect to be given an explanation of what the treatment will involve	-	Y	Y	Y	-
3	I expect to be able to negotiate the cost of my treatment sessions if necessary	-	-	-	Y	-
4	I expect to be given a choice of appointment times	-	-	-	Y	Y
5	I expect to be given information about the benefits of treatment	-	Y	-	Y	-
6	I expect to be given information about the risks of treatment	Y	Y	-	Y	-
7	I expect to sign a consent form prior to treatment	Y	Y	Y	Y	-
8	I expect the osteopath to display evidence of their professional qualifications	-	-	-	Y	-
9	I expect to have the choice of a male or female osteopath	-	-	-	-	-
10	I expect to see the same osteopath each time	-	-	Y	Y	-
11	I expect to be offered a chaperone or permitted to bring my own if I wish	Y	-	Y	-	-
12	I expect the environment to be hygienic and professional looking	-	Y	-	-	-
13	I expect the waiting area to be comfortable and relaxing	-	-	-	Y	-
14	I expect the consultation to last at least thirty minutes.	-	Y	-	Y	-
15	I expect the osteopath to only treat one patient at one time	-	-	-	Y	Y
16	I expect to be reassured that the information that I am asked to provide will be kept confidential	Y	Y	-	Y	Y
17	I expect the osteopath to write a detailed account of my personal history.	Y	Y	Y	Y	Y
18	I expect the osteopath to be sympathetic and caring	Y	Y	-	Y	-
19	I expect to be involved in making decisions about my treatment	-	-	-	Y	Y
20	I expect the osteopath to make me feel at ease	Y	Y	-	Y	-
21	I expect be given privacy when undressing for diagnosis and treatment.	Y	Y	Y	Y	-
22	I expect to be provided with a gown when undressed.	-	-	Y	Y	-
23	I expect the osteopath to examine my specific problem area with her/his hands.	-	-	-	Y	-
24	I expect to receive vigorous osteopathy e.g manipulations	-	-	-	Y	-

		Code of Practice	NCOR3	Kelly Green	Patient Interviews	Literature review
25	I expect to receive gentle osteopathy e.g cranial	-	-	-	Y	-
26	I expect to receive electrotherapy e.g ultrasound	-	-	-	-	-
27	I expect the osteopath to monitor my reaction to his treatment	-	-	-	Y	-
28	I expect to be given a clear diagnosis of my problem.	-	-	Y	Y	Y
29	I expect to be given a clear explanation of my problem that I understand	Y	-	-	Y	-
30	I expect to be told how many treatments I will need	-	-	Y	Y	-
31	I expect my osteopathic treatment to be value for money	-	Y	-	Y	-
32	I would forgo some luxuries to be able to afford osteopathic treatment	-	-	-	Y	-
33	I expect treatment to be painless.	-	-	-	Y	-
34	I expect my symptoms may get worse following treatment	-	Y	-	Y	Y
35	I expect to be able to ask questions	Y	Y	-	Y	-
36	I expect my questions to be answered to my satisfaction	Y	Y	-	Y	-
37	I expect to be asked about effects of previous treatment	-	-	-	Y	-
38	I would expect there to be communication between my osteopath and GP if necessary	Y	-	-	Y	-
39	I expect the osteopath to refer me elsewhere if my symptoms are not improving	Y	Y	-	Y	-
40	I expect to be given advice about how to manage the symptoms myself	-	-	-	Y	Y
41	I expect to be able to phone the osteopath for advice if I needed	-	-	-	Y	-
42	I expect to be given advice on how to prevent the same problem happening again	-	-	-	Y	Y
43	I expect to be given activities or exercises to do at home	-	-	-	Y	-
44	I expect to be given a timeframe for improvement of symptoms	-	-	-	Y	-
45	I expect to feel some pain or discomfort following treatment	-	Y	-	Y	Y
46	I expect to be able to return to my normal activities soon after treatment	-	-	-	Y	Y
47	If I am not satisfied with any part of my treatment I would expect to be given information about how to make a formal complaint	Y	Y	-	-	-
48	I expect the practice to make provision for people with disabilities	Y	-	-	Y	-

Appendix 9. The Survey Pack sent to osteopaths including one Patient Questionnaire Pack

Contents:

The Questionnaire is a PDF under separate cover

(Letter to osteopaths: University of Brighton headed paper)

01273 643457
c.m.j.leach@brighton.ac.uk

February 2010

Dear <osteopath>

OPEn Project: Investigating patient expectations of osteopathic treatment

I am writing to invite you to assist with a survey of 8000 osteopathic patients recruited from 800 osteopathic practices in the UK. You were one of the 800 osteopaths selected by random sampling from the GOsC register. The data from your patients will help us to create a representative profile of current patients' views.

The study aims to gain a deeper understanding of patients' expectations of osteopaths and osteopathic treatment. It is the first study of its kind within osteopathy, and is being funded by the General Osteopathic Council. We believe the osteopathic profession will gain knowledge concerning patients' goals, which will benefit future patients by helping to improve standards of patient care, increase patient satisfaction, and ultimately improve outcomes.

We would like you to invite 10-14 of your patients to participate in the study and to give them one of the enclosed Participant Questionnaire Packs. We have included loose copies of the documents in the Packs for you to read, if you wish. Each Pack contains a letter of invitation, some Participant Information Sheets, the specially-developed questionnaire about expectations, and a reply-paid envelope for return of the completed questionnaire to the researchers. The questionnaire has been designed with input from osteopathic patients.

Annex 1 to this letter tells you what is involved in participating in the study. When you have read all the information, you can decide if you wish to take part. I do hope you will be able to support the study

Yours sincerely,

Janine Leach

Dr Janine Leach
Senior Research Fellow in Osteopathy

Annex 1. Protocol for Osteopaths participating in the survey

OPEn Project: Investigating patient expectations of osteopathic treatment

Why is the study important?
The aim of the project is to gain a deeper understanding of patients' expectations when they visit an osteopath. The survey will gather new information about patients' expectations and assess to what extent osteopaths in the UK meet these expectations. We hope the results will give us important information that will help us to understand what patients want and expect from osteopathic care and treatment, and how we can improve the care given to osteopathic patients in the future.
Further information about the study can be found on the study web site
http://www.patientexpectationstudy.org.uk/

Why have I been invited?
Your name was one of 800 names in a random sample drawn from the GOsC Register. In order to obtain an accurate profile of current patients' view, we need a large sample of osteopaths, each inviting a small number of patients. This will provide a large enough sample of patients to get accurate statistics, and sufficient osteopaths to represent different types of practice. We have used a random sample because that is the most scientifically rigorous way to represent the varied practices in the UK.

Is my practice eligible?
We have not yet requested NHS Ethical approval for conducting the survey in NHS sites, so **if you are employed by the NHS you are not eligible**; i.e. seeing NHS patients on NHS premises. Please could you let us know immediately if this is the case and we can replace you with another randomly-drawn member of the profession.

(Please note that we cannot replace osteopaths who simply do not wish to participate: they will reduce our response rate and sample size, and weaken the results of the survey).

What am I being asked to do?
All we ask is that you give a Participant Pack to each of 10-14 eligible patients. The patients will take the Pack home, where they can decide if they wish to participate in the study. A stamped addressed envelope is included in each Participant Pack, so that the patient can post their completed questionnaire to the researchers at the University of Brighton.

Which patients are eligible?
All current patients attending your practice are eligible, including adults, children and those with disabilities, provided they can understand the questionnaire and have the capacity to consent to completing the questionnaire.

For children under 16 years, the questionnaire can be completed by a parent or guardian on their behalf, if the child consents.

Which patients do I recruit?
We want you to use a strict recruitment protocol, in order to avoid bias in the sample. Please follow these three steps.

1. Invite 10 consecutive eligible patients, starting on the first available Tuesday at 9 am and continuing each day in practice till you have invited 10 patients. If you are not in practice on Tuesday, start on your next practice day of the week. When you start, please make a note of each patient you see, the date and time, whether or not they are new patients to your practice, and whether they were invited to participate. We have supplied a table to assist with this, below at Table 1. We hope that your first ten patients will include at least four new patients, but if not please continue with step 2, adding new patients only.

2. Continue to invite subsequent consecutive <u>new</u> patients, if necessary, until 4 new patients have been invited from your practice. When you have four new patients, your sample is complete.

3. Stop recruiting one month after the start date, even if you have not recruited the full quota.

NOTE: IT IS REALLY IMPORTANT TO STICK TO THIS PROTOCOL STRICTLY, TO AVOID BIAS

Is there anything else I should mention to patients about the study?
Please tell patients a little about the study aims, perhaps mentioning that the study will provide important information to enable osteopaths to improve the care of patients.
Further information is included in the Participant Information Sheet.

Patient confidentiality is assured since the questionnaires are identified by a study number only. You will not know if they participate or not, and will have no knowledge of what views they have expressed.

There is a very small risk that the questionnaire could bring up memories which a patient finds disturbing or distressing. We consider it very unlikely to be needed, but if necessary please offer further psychological support, for example by referral to their GP or to a counsellor.

What to do when you have finished
When you have completed the recruitment protocol above, you have completed your part in the study. Please could you help us by returning Table 1 (overleaf) to the researchers? This Table will help us to estimate the proportion of all osteopathic patients that were eligible for the survey.

Your participation in the survey is much appreciated and will help in creating a high quality study that will help the osteopathic profession to meet patients' expectations.

The importance of the study should not be under-estimated and we do hope that you decide to participate.

Thank you for your time

Table 1: Patient recruitment for the OPEN project questionnaire survey

Name of osteopath **……**

Postcode of practice **……**

Please list ALL patients you see from the start date and time, including those you do not invite to participate, till end of recruitment

Date	Appointment time	Patient ID* (your ref)	New patient? Yes /No	Invited to participate? Yes/No	Reason why not invited **

Patient ID: please do NOT record the patient's full name for reasons of confidentiality
****The patient may be ineligible if they are a non-English speaker, or unable to understand the questions, or they do not have the capacity to consent***

Please return this sheet to Laura Bottomley, Clinical Research Centre for Health Professions, University of Brighton, 49 Darley Road, Eastbourne, BN20 7UR
Telephone: 01273 643457 Fax: 01273 643944
Email: l.m.bottomley@brighton.ac.uk

(invitation letter for patients)

University of Brighton

Dear Sir/Madam,

OPEn Project: Investigating patient expectations of osteopathic practice

I am a researcher at the University of Brighton. I am writing to invite you to take part in this study to find out about patients' expectations of osteopathic practice.

To tell you about the study, there are three Information Sheets to choose from in the envelope you received from the osteopath. The first one provides the most detail and the second and third Information Sheets are easier to understand. You can choose the one you prefer. When you have read it, you can decide whether or not you want to take part.

Taking part simply involves completing the questionnaire you received with this letter, which takes about 15 minutes. If you do not wish to take part, that is fine. If you do decide to take part, please complete the questionnaire as honestly and openly as you wish, and return it to the researchers in the postage-paid envelope provided.

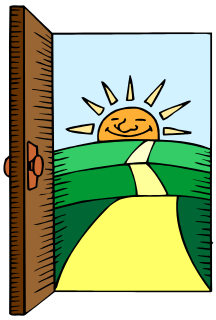
If you would like more information about the study, call 01273 643457 and ask to talk to me or one of the other researchers on the Open Project. We will do our best to answer your questions. Further information about the study is also available on our web site: http://www.patientexpectationstudy.org.uk/

Thank you for taking an interest in our study.

Yours sincerely

Dr Janine Leach
Senior Research Fellow in Osteopathy

Telephone: 01273 643457



University of Brighton

Participant Information Sheet for the survey

OPEn Project: Investigating patient expectations of osteopathic practice

You are invited to take part in a research study. Before you do so, it is important that you understand why the research is being done and what is involved. Please take time to read this information and ask us if there is anything you are not clear about. Take time to decide whether or not you wish to take part.

Why are we doing this study?
We are trying to find out what patients expect when they first come to see an osteopath. We want to know about what patients expect about a whole range of things such as what treatment might be like, what improvement you expect and what might be different about seeing an osteopath compared to a medical doctor or GP.

This is the first study of its kind in the UK. We are collecting information by asking 8000 patients who are attending 800 osteopathic clinics to complete questionnaires.

Why have I been invited?
Your osteopathic clinic is one of the 800 clinics taking part in the study. Your osteopath has been asked to invite men and women who are currently having osteopathic treatment to participate in the study. To avoid bias, only certain patients attending on certain days will be invited to complete questionnaires. Everyone taking part will need to be able to read and understand English.

Do I have to take part?
No, you are free to choose whether to take part or not. When you have read the Information about the study, it is up to you to decide if you want to take part in the study. Whatever your decision, it will not affect the care that you receive from your osteopath.

What will happen to me if I take part?
If you decide to take part, simply complete the questionnaire, which takes about 15 minutes. Please return it to the researchers in the reply-paid envelope. There will be no other questionnaires to complete in the future as part of this study.

What will come out of the study?
The researchers will analyse the information from the returned questionnaires. We hope to gain a lot of new information about patient expectations when visiting an osteopath and to find out whether osteopaths in the UK meet these expectations. We hope the results will give us really important information that will help us to understand what patients want and expect from osteopathic treatment, and how to improve the care given to osteopathic patients in the future.

We will write a report about the results, as well as a leaflet for patients and a leaflet for osteopaths. All the data presented in the report and leaflets will be anonymous. There will be some numbers and graphs and maybe some short quotes from patients, selected from the questionnaires. These will all be anonymous. The reports and leaflets will be available from our web site, or you can ask for a printed copy to be sent to you.

Are there any risks or benefits of taking part?
There are no direct risks or benefits to you, but your views may benefit future patients by helping us to understand what is important for patients seeking osteopathic treatment.
There is a small possibility that the questionnaire could bring up memories which you find disturbing or distressing. In that event, you should contact the osteopath who is treating you, or your GP, who will direct you to appropriate support.

Will my details be kept confidential?
This study was checked carefully by two ethics panels* before we started, to make sure that we respect patients' rights, privacy, confidentiality and safety.
All the data collected in the study will be anonymous and will be stored securely at the University of Brighton until the end of the study. Only the researchers will have access to this information. No personal data will be stored. The research will not reveal to your osteopath, or to anyone reading the results, who took part in the study or what information they contributed.

The only exception to total confidentiality would be in the unlikely event that information on a questionnaire suggested very serious misconduct by an osteopath. In that instance, the researchers would have a legal obligation to trace the practice concerned and to inform the General Osteopathic Council. The code which is printed on the top of the questionnaire permits us to identify the osteopathic practice but not the patient participant. All participants remain anonymous.

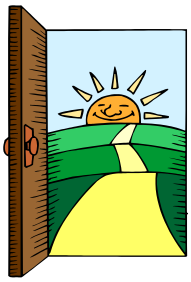
Who is organising the research?
The General Osteopathic Council has asked the University of Brighton to conduct the study. Dr Janine Leach is the researcher who is leading the project. She can be contacted at:
Clinical Research Centre for Health Professions, University of Brighton, Aldro Building, 49 Darley Road, Eastbourne, BN20 7UR
Telephone: 01273 643457 Email: c.m.j.leach@brighton.ac.uk
Web site for this project http://www.patientexpectationstudy.org.uk/

***The ethical panels that have checked this study are:**
- The South East Research Ethics Committee, NHS National Research Ethics Service
- The Faculty of Health and Social Science Research Ethics and Governance Committee, University of Brighton

University of Brighton

Easy-to-Understand Participant Information Sheet

for reading ages 10-14 years



OPEn Project: to find out what patients expect when they go to an osteopath

Why are we doing this research?

We are a group of researchers and osteopaths from the University of Brighton. Research means we are trying to find out the answers to questions. We want to find out from patients what they like and don't like about going to see an osteopath for treatment.

We want to you to think about questions like:

How do you like the osteopath to talk to you?

How do you like to be treated in the clinic?

Do you like the place where the osteopath works?

Are there things that would make it better when you go there?

To try to get the answers, we are inviting you and lots of other people to fill in a questionnaire about their osteopathic treatment. You can fill in the questionnaire with your parent or guardian, and then send it to us. The questionnaire takes about 20 minutes to fill in.

Do I have to take part?

No, it is up to you. If you decide not to take part, this will not affect the care that you receive from your osteopath.

What will happen to the data collected in the study?

The data from all the questionnaires will be sent to the University, and put onto a computer. The researchers will produce statistics, such as tables and graphs.

At the end of the study there will be a report which you will be able to see if you wish.

Is there anything I should worry about if I take part?

We cannot promise, but we don't think the questions will worry you, and we hope that the information will help to make osteopaths better at providing what patients want and expect in the future.

Will my details be kept private? Will anyone else know I am doing this?

All the questionnaires collected in the study will be kept in a locked cupboard at the University of Brighton. Your name will not be on the questionnaire so no-one will know which one is yours once you send it off. Only the researchers will see your answers.

Who is organising and funding the research?

The General Osteopathic Council (GOsC) has given money to the University of Brighton to organise the research. The GOsC has also asked a group of experts to help the researchers do the project as well as possible.

Did anyone check the study is OK to do?

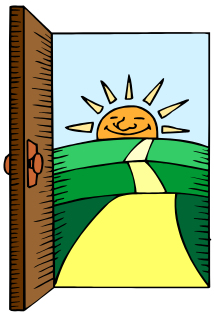
Before any research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. Two Committees have checked this project, one organised by the NHS Research Ethics Service and one organised by the University of Brighton.

Contact for Further Information:

Dr Janine Leach
Clinical Research Centre for Health Professions
University of Brighton, Aldro Building, 49 Darley Road, Eastbourne, BN20 7UR
Telephone: 01273 643457 Email: c.m.j.leach@brighton.ac.uk
Web site for this project http://www.patientexpectationstudy.org.uk/

Very easy-to-understand Participant Information Sheet for reading ages 5-9 years

For parents or guardians to use to read to the young person to explain what the study is about



The OPEN Project

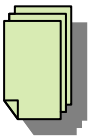
A person called Jan Leach has sent you a list of questions. The questions are about what you like and don't like about going to see an osteopath for treatment.

How do you like the osteopath to talk to you?

How do you like to be treated in the clinic?

Do you like the place where the osteopath works?

Are there things that would make it better when you go there?



If you want to tell us what you think, your mother or father will help you to fill in the Questionnaire. **If you don't want to answer the questions, that's fine.**

Lots of people have checked the study, to make sure the University keeps your details safe and to make sure that the study will be useful to patients who have go to see an osteopath.

If you want to know more about it, you can call Jan Leach on 01273 643457

Appendix 10 Computing the extent of unmet expectation

For each aspect of expectation, A, participants were allocated into one of four groups according to their responses to the questions "did you expect A?" and "did A happen?". The four kinds of response are represented in the table below as alb, c, or d.

Did you expect A?

Did A happen?	**YES**	**NO**
YES	**a**	**c**
NO	**b**	**d**

Extent of Unmet Expectation of A = $\frac{\text{Number for whom A did not happen}}{\text{Total with positive expectation of A}}$

$$= \frac{b}{(a+b)}$$

This proportion was expressed as a percentage in the results section.

Appendix 11. The theoretical basis for plotting expectation against delivery of care

The 12.5% cut-off on the horizontal axis in Figure 3 was based on a metric used in management science of a "net promoter score" of less than 75% (Reichheld 2003).

Important expectations were defined as those expected by more than 75% patients, for the cut-off on the expectations scale.

The Net Promoter Score is derived by subtracting the percentage of Detractors from the percentage of Promoters in the customer base (the "passive" customers have been ignored in this approximation). The assumption was made that Detractors were those with high levels of unmet expectation, and the Promoters were those with low levels of unmet expectation. The ideal is for the Net Promoter Score (from subtracting the two) to be 75% or above. When the cut-off for acceptable levels of unmet expectations at 12.5%, the difference between the two scores is then 76%.

Reichheld, F. (2003). "The one number you need to grow." Harvard Business Review(December 2003)

Appendix 12 Additional questions for future surveys

Several additional aspects of expectation were identified in the survey through the free text questions which asked patients to name their "most important expectations", in their own words. The following points emerged which were not specifically covered in the questionnaire:

- To have an immediate, perceptible improvement in symptoms
- To be able to return to their normal activities/have an improved quality of life
- To be given a clear and honest explanation of their problem and what can be achieved
- Their problem to eventually resolve completely as a result of the treatment
- To receive appropriate, effective treatment.

In addition, some patients mentioned unexpected treatment modalities such as acupuncture (33 mentions), cranial osteopathy (20) and ultrasound (8) which may need to be specifically asked about.

Some **additional question** may therefore be valuable in future surveys to find out:

- whether patients expect the osteopath to discuss what the treatment might be able to achieve;
- how much symptom improvement patients expect, and how quickly;
- how much effect on function and quality of life are expected;
- to test attitudes to "non-osteopathic" treatments such as acupuncture or homeopathy or to less common osteopathic approaches.

Appendix 13.

The final printed questionnaire