General Osteopathic Council

Response to the Osteopathic Practice Standards Consultation

April 2011

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Introduction

1. The General Osteopathic Council (GOsC) is required by the Osteopaths Act 1993 (the Act) to:

   a. Determine the Standard of Proficiency required for the competent and safe practice of osteopathy and publish a statement of that standard[1].

   b. Publish a Code of Practice laying down the standards of conduct and practice expected of a registered osteopath and give guidance in relation to the practice of osteopathy[2].

2. Strategic Objectives 1 and 2 of the General Osteopathic Council's Corporate Plan requires us to review and publish a revised *Code of Practice* and *Standard of Proficiency*.

3. The current *Standard of Proficiency (Standard 2000)* was published in March 1999 and came into force in March 2000. The current *Code of Practice* was published and came into effect in May 2005. Both documents were previously revised under the guidance of working parties established by the Council. A consultation on a revised draft *Code of Practice* and *Standard of Proficiency* took place from November 2008 – July 2009 and a consultation report was produced in December 2009. The report was considered by the GOsC at its meeting in January 2010. The revised *Code of Practice* had not been subject to a separate consultation, although preliminary feedback was sought from the profession during 2009, which was used to produce a revised draft.

4. Whilst both documents had been developed separately, in January 2010 the Council considered the relationship between them and concluded that, for reasons of clarity and ease of reference for the user, it wished to consult on a single document which incorporated the two. A combined consultation document entitled Osteopathic Practice Standards (OPS) was produced and this incorporated both the *Standard of Proficiency* and *Code of Practice*.

5. In July 2010, Council agreed that the draft OPS should be published for consultation with the profession, the public and other stakeholders. The consultation began on 1 September 2010 and ended on 30 November 2010.

[1] Osteopaths Act 1993, section 13
[2] Osteopaths Act 1993, section 19

Conducting the consultation exercise

1. Following an open tender exercise, the GOsC recruited independent consultants Hewell, Taylor, Freed & Associates Ltd (HTF) to conduct the consultation exercise on its behalf. The GOsC worked closely with HTF to develop the consultation, however, the consultation itself was conducted independently of the GOsC and all responses were collected and analysed by HTF.

2. The methodology used by HTF to target a range of osteopaths' views, as well as feedback from other stakeholder groups, is documented in its consultation analysis report.

3. Separately, the GOsC commissioned an equality impact assessment from freelance equality and diversity consultant Agnes Fletcher, to identify any equality and diversity issues that may arise from the introduction of the new standards.

Key findings from the consultation

1. The key findings from the consultation are presented in the reports of Hewell, Taylor, Freed & Associates Ltd and Agnes Fletcher.

2. All stakeholder groups were generally supportive of bringing the *Code of Practice* and *Standard of Proficiency* together in one document. They were also generally supportive of the format and the overall language of the document.

3. The reports did, however, identify a number of key findings which required further discussion. There were clear messages from osteopaths that some areas of the Osteopathic Practice Standards required further clarification or were 'unworkable' in practical terms. These areas included consent, intimate areas, modesty and chaperones.

4. Patient groups also identified areas of the document where further clarity was required, although these sometimes conflicted with the views of osteopaths. For example, this was evident in the use of the term 'diagnosis'. Although patient groups considered this clear and easily understood, osteopaths felt it did not sufficiently convey the process of identifying a number of osteopathic hypotheses which could be explored further and refined at subsequent consultations.

5. Professional associations were concerned that the GOsC might be overstepping its remit and allowing 'regulatory creep' throughout the document.

6. Osteopathic Educational Institutions were keen to strengthen some areas of the standards, particularly around record keeping and the use of information technology (IT), while others in the profession did not want to see such a requirement.

7. It was clear to the GOsC that further consideration needed to be given before publishing a final version of the Osteopathic Practice Standards.

GOsC response to the consultation analysis report and the equality and diversity report

1. The GOsC established an Osteopathic Practice Standards Working Group to ensure that the feedback from stakeholders was used to inform the development of the document. The Group was tasked with:

   a. critically reviewing the final consultation analysis report and the equality impact assessment
   b. making recommendations to Council on:
      i. any amendments required to the consultation draft of the Osteopathic Practice Standards;
      ii. the timetable for publication of the final Osteopathic Practice Standards document.

2. The Group consisted of three lay and three osteopathic members of Council as detailed below:

   Professor Julie Stone (Working Group Chair, lay)
   Professor Ian Hughes (lay)
   Miss Fiona Walsh (osteopath)
   Mr Kenneth MacLean (osteopath)
   Mr Nick Hounsfield (osteopath)
   Miss Jenny White (lay)

3. The group made recommendations to the Council which were considered and agreed at its meeting of 12 April 2011.

Discussion and agreed action

Discussion points and actions have been grouped under the headings below. Click on a heading to go to the relevant section.

Combining the *Code of Practice* and *Standard of Proficiency*

1. In general, respondents found the 'new' Osteopathic Practice Standards a useful document and felt that combining the *Standard of Proficiency* and *Code of Practice* was a good idea (97% of those who returned questionnaires or contributed to focus groups agreed with the proposal). The remaining respondents expressed the need for further guidance on the primary target audience and how the GOsC expected the standards to be used.

2. The overwhelming majority of the individuals interviewed from Osteopathic Educational Institutions and Osteopathic Postgraduate Training Providers agreed that it was a good idea to combine the two documents and they liked the format and layout. Comments included:

   a. *'It relates two areas together, as two documents they can appear unrelated. This document makes the practitioner think of the two together which they should.'*
   b. *'Very positive move and long overdue'.*

3. Other stakeholders were broadly in agreement with the proposal to publish the two documents together, although particular reservations were expressed by one of the GOsC Fitness to Practise (FtP) committees. It commented:

   a. *'...This has the potential for making clearer the GOsC's intended linkage between the two (Code of Practice and Standard of Proficiency) in judgements of whether or not practice failings which are found proved amount to unacceptable professional conduct (UPC). However...the revised CoP does not spell out the reliance on the Standard of Proficiency in respect of matters of practice that the GOsC intends in assessment of UPC. Nor does the Code of Practice as yet contain sufficient content on practice.'*

4. The two GOsC Fitness to Practise committees did, however, agree that combining the two documents was a good idea.

5. This feedback gives the GOsC a clear mandate to combine the publication of the *Code of Practice* and *Standard of Proficiency* in one document. Whilst the document is designed to outline the standards required of osteopaths and provide guidance on how these might be met, the document needs to be appropriately worded for all audiences. This needs to be taken into account when considering all drafting changes.

6. The feedback from the FtP committees (see 3 a.) suggested that there is currently a gap in the *Code of Practice* which prevents FtP committees from using the *Standard of Proficiency* when reaching decisions in conduct-related cases. This is an interpretation of the Osteopaths Act 1993 where conduct issues related to the *Code of Practice* are dealt with under Section 19 and incompetence issues are related to the *Standard of Proficiency* under Section 13.

7. The GOsC has previously sought legal advice which stated that both the *Code of Practice* and the *Standard of Proficiency* are of equal standing in determining the unacceptable professional conduct of an osteopath, whether this is through conduct or incompetence. There should be no distinction in the use of either the *Code of Practice* or *Standard of Proficiency* at Fitness to Practise hearings.

8. The GOsC believes that there may be specific cases that do not easily fall within either the Code or the Standard, but this would not prevent the case from being taken forward by the GOsC. The Osteopathic Practice Standards therefore need to be sufficiently flexible to allow their application in a wide range of scenarios whilst still being fair to the osteopath.

Agreed action: To publish the *Code of Practice* and *Standard of Proficiency* as a combined document under the title Osteopathic Practice Standards.

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Format and language of the document

9. The format and overall language of the document were seen as positive by the majority of respondents. There are specific comments on the language and content made under each section, but these will be dealt on an individual basis.

10. The consultation analysis report states that:

    a. 'The layout and format of the document was generally liked. 90% of all respondents liked the format, with 83% of those who added comments on what they liked about it expressing support for the document's clarity and conciseness, use of language and the visual layout. Many commented that they really liked the two colours as they felt it added to the clarity of the document. Others commented that the colours used were in fact very similar, this created difficulties when printed off in black and white and also for anyone who is colour blind. A substantial number did feel that it might assist the clarity of the document if the 'standards column' was all shown in a bold typeface.'

    b. 'Over 70% of respondents stated explicitly that the document was an improvement on the previous ones, with comments ranging from 'a fair first draft' to 'overall an excellent document'. A number of professional respondents expressed the opinion that they were pleased that GOsC was listening to the profession, in the pursuit of patient and public protection. Comments which reflect some of the positive feedback we received from the profession include:
        a. 'a huge improvement on the previous documents.... helpful for the schools to teach to'.
        b. 'Important to protect patients against the few bad practitioners, but so much is commonsense anyway'.
        c. '... not too directive or prescriptive for the experienced practitioner, and sufficient to assist the newly qualified'.
        d. 'Good, normal language... Important to be seen to be doing this - shows the level of aspiration for the profession'.
        e. 'I was initially concerned about how it would be achieved, but very pleasantly surprised with how it has come out'.
        f. '...a good document; it sets the boundaries for interaction between osteopath and patient'.
        g. 'Very good to be doing this - a valid approach. Conciseness is spot-on - enough guidance on osteopathic consultation balanced with how to run your business. Might have helped to have some of this drip-fed into the last year of training'.

h. 'It does its job: the document could have been much bigger, given the task in hand, so its current size is to be welcomed...'
i. 'Straightforward and comprehensive'.
j. 'Clear and easy to read'.
k. '...in general seems good...'
l. '(We) consider this a much better document than the previous two; though would like to have an additional document which is "chattier" than the guidance. This would be particularly helpful for section D, as good examples could be provided in that type of document'.
m. From British Osteopathic Association (BOA): 'Our overview is that the document is generally acceptable and well constructed...'
n. The Osteopathic Educational Institutions (OEIs) liked the format and layout. There were really very few 'criticisms' or amendments requested by the Osteopathic Educational Institutions and Osteopathic Postgraduate Education Training Providers. With the vast majority being very positive about it. The following comments are typical:
    i. 'I should say that I do not agree with minimum standards, we should always try to rise to a higher standard, shouldn't drop to the lowest common denominator; however I am not suggesting this document does that.'
    ii. 'This is a big improvement on previous documents.'
    iii. 'Very carefully worded and fair and inclusive'.
o. Students responding to the consultation were positive about the format and layout saying that the things particularly liked about the document were:
    i. 'The clear unambiguous writing style'
    ii. ' There is minimal repetition to that which would occur in two publications'
    iii. 'It is very easy to overview, nicely divided and the colours make it easy to navigate your way through'.'

11. This gives a firm basis to proceed with publishing the document based on the consultation format.

Agreed action:

a. To publish the Osteopathic Practice Standards based on a format which:
    i. mirrors the revalidation assessment headings;
    ii. maintains the split between the Code and *Standard of Proficiency* sections;
    iii. uses two colours to define the *Code of Practice* and *Standard of Proficiency* – the use of colour will be explored with the design company to ensure that the document is accessible. An option would be to have several formats available, i.e. black and white, large print, as well as the main design;
    iv. finds a balance between short statements of standards and further expanded text in the guidance; and

v. uses accessible 'plain English' to communicate to a wide range of audiences.

b. The document should be externally read to ensure that the language is plain and accessible to a wide range of audiences.

c. The standards should be highlighted in bold text.

Standard C9

12. It was felt that the following standard was too absolute and would be impossible for osteopaths to achieve:

'C9. Act quickly to help patients and keep them from harm, whatever the cause.'

13. Removing 'whatever the cause' from the end of the sentence would retain the meaning whilst removing any unrealistic expectation that osteopaths will be able to maintain patient safety no matter what circumstance or situation arises.

Agreed Action: To remove 'whatever the cause' from the end of standard C9.

The Language of Section B

14. The consultation report states that:

'Respondents commented that descriptions such as 'sufficient', 'adequate' and 'advanced' would need definition in order to be assessable or measurable in this context. *"Court-proof"* was an expression used by one respondent, and others observed that throughout this section, it would be difficult to demonstrate that the osteopath had acted competently. For example, standard B2 2.4, which caused concern for some respondents: 'for some, the "degree" of sufficiency needed to be explicit'.

15. A specific response from a patients' group states that:

'... the wording of some key standards is such that they would not be capable of standing alone without the accompanying guidance. For example, in section B, the terms 'adequate' understanding and 'sufficient' knowledge fall far short of inspiring public confidence in terms of the standards apparently being aspired to.'

16. In the GOsC study of patient expectations (the OPEn study), it was found:

    '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.'

    '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.'

17. This document is not intended to list a set of criteria or a curriculum for osteopaths to meet. The idea is to provide the high-level standards required for practice and provide guidance on how these might be attained. For more rigorous criteria you would need to refer to an educational document. The GOsC intends to look at this area as part of its pre-registration curriculum review.

18. In terms of being 'court-proof', fitness to practise cases will draw on the expert testimony of osteopaths to define what a 'reasonable' osteopath would be expected to know or do in a particular circumstance. Therefore the wording of this document does not have to be drafted in legal terminology to cover every eventuality. Having said this, the wording should be clear and leave no-one in doubt of what is expected of an osteopath.

19. Some of the adjectives used in sections B1 and B2 can be slightly ambiguous, especially where these are not linked to an outcome. All statements should be reviewed to ensure that the wording is adequately referenced and not open to interpretation. For example, if the term 'sufficient' is to be used, then the purpose of why the osteopath should be sufficient should also be given, as in the standard B2: You must have sufficient knowledge and skills to support your work as an osteopath.

    Agreed action: Revise wording of standards and guidance at B1 and B2, in terms of adjectives used, to ensure clarity.

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Distinguishing standards from guidance

20. The consultation analysis report states that:

> 'Again 100% of the focus group attendees stated that there are a number of guidance points which contain the words 'must' and 'should'. This makes the guidance appear to be prescriptive or mandatory and therefore it is no longer guidance. This feedback was also received from a very large proportion of the telephone interviewees and usually it was suggested that the words 'must' and 'should' had no place in guidance. The fact that these words were there did, we felt, create confusion on what guidance actually was and how it would be 'used', and also it created concern for these reasons. Our observation would be that it also, for some osteopath respondents, created a reason for a degree of mistrust.'

21. The GOsC needs to be clear in its message describing what standards and guidance are and how they will be used. This requires clear wording in the introduction to the document.

22. The standard outlines what the osteopath 'must' achieve, whereas the guidance provides a guide to how this should normally be achieved, whilst maintaining the flexibility for osteopaths to make alternative decisions based on the circumstances both clinical or otherwise.

23. It is important that the guidance does not contain any definite statements of what 'must' be done in every circumstance. If something 'must' be done in every circumstance no matter what, then this should become a standard.

24. It was often suggested that case studies/examples/definitions were needed. In the consultation analysis report, Hewell Taylor Freed & Associates Ltd suggest that:

> 'Although we understood and fully appreciated these points, our opinion was and remains that this document is not the place for such things. However, we do feel that there would be considerable value in making this provision with perhaps the addition of frequently asked questions (which could be a 'live' document). This may of course fall more within the remit of a professional body rather than the regulator.'

25. A quote from a patient response questioned whether the guidance provided was sufficient or whether it should contain more detail:

    a. '*...there are gaps in the guidance where more detail would be beneficial. However, it is not clear whether it would be practical to include more detailed guidance within the document without making the document too cumbersome and that it may be*

preferable to develop separate more detailed issue specific guidance documents where appropriate. There are some areas where the guidance is possibly at risk of taking on the role of a 'training manual' rather than core guidance and others where not enough guidance is provided but this may be where having separate more detailed guidance documents would be beneficial to complement the core guidance provided within the main document'.

26. A comment from a GOsC Fitness to Practise committee is helpful here:

    a. *'We need to avoid setting out detailed rules and instructions, which in my view devalue the Code as a set of principles, and it's important that osteopaths take responsibility for using their professional judgement. Of course, if there is a complaint, they have to be able to demonstrate the soundness and integrity of that judgement.'*

27. It is important that the OPS is easy to read and refer to, and does not become overly burdensome or complex. It is not intended for this document to be a training manual or to cover every possible situation which may arise in practice. It is also important to bear in mind that the law and guidance are constantly changing so it is essential for the GOsC to produce detailed guidance in a form which can be quickly updated and adapted should the need arise.

28. On this basis, it would be sensible to identify the areas where further detailed guidance is required and then to develop this supplemental guidance to support the OPS. The supplemental guidance could be published separately on the GOsC website and be updated independently of the OPS. This would keep the OPS document manageable and not overly complex.

Agreed action:

a. Clear wording that explains the difference between standards and guidance should be included in the introduction to the document.

b. The language used in the standards and guidance should reflect their purpose. Changes to the wording of the guidance would be made to replace 'must' with 'should' or 'may'.

c. The guidance sections should be clearly referenced so that it is easy to link the relevant guidance to the corresponding standard.

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Consent

29. The main feedback from the consultation on consent can be summarised as follows:

    a. **Valid consent:**

        i. **Ongoing consent** – there was concern from osteopaths about the need to receive ongoing consent and consent for each procedure. Many interpreted this as needing to continually stop their examination or treatment to receive explicit oral or written consent from the patient. Others asked why it was not possible to rely on the patient's attendance at the clinic as implied consent to all treatments.

        ii. **Explaining risks** – concerns were raised by osteopaths about the need to explain risks associated with the proposed procedures. Osteopaths are primarily concerned about the lack of quality information available for them to determine what the associated risks are and to be able to quantify these risks for their patients.

    b. **Form of consent:** The distinction between the process of seeking consent (i.e. communication) and the form in which a patient can provide their consent (i.e. implied, oral or in writing) seems to have been misunderstood.

30. The concerns raised relate to the guidance on communicating risks and seeking valid consent. The relevant standards appear to be acceptable.

Valid consent

31. In drafting the standards and guidance on consent, the GOsC referred to the law on consent. It also referred to the Department of Health's *Reference guide to consent for examination or treatment, second edition* 2009 (DoH guidance) and the requirements and guidance set out in the codes of practice published by other healthcare regulators.

Ongoing consent

32. Standard A4, guidance paragraph 12 explains the elements of valid consent. Concern here has been raised about the need to secure the patient's consent to 'each distinct procedure'. Similar concerns are raised about the guidance given in guidance

paragraph 14 of standard A4, which explains that 'consent can only be obtained for a specific treatment at a specific point in time'. It is recognised that osteopathic examination and treatment does not always easily fit into this structure of seeking consent. This is explained in the following consultation response:

> *'The whole issue of consent needs to be thought through more carefully in light of the fluid nature of osteopathic practice. Most osteopathic treatment does not follow the model under which techniques are initially taught (as isolated procedures) but unfolds as an exploration of the patient's body in which evaluation and treatment merge together and so-called techniques flow one into the next, with the continuity of this flow and the resultant sedative effect on the nervous system being a significant factor in the effectiveness of the treatment. Hence obtaining specific consent for each distinct procedure, at least in the temporal sense, would compromise the treatment and is therefore inappropriate. For these reasons, points 12 and 14 are unworkable.*
>
> *The approach described in point 15, where the likely range of approaches is described and consent obtained before commencing treatment is altogether a more sensible starting point for discussing consent as it most closely reflects how the majority of osteopaths approach obtaining consent in practice.'*

33. Standard A4, guidance paragraph 15 reads: 'In a case where your diagnostic examination and treatment are carried out simultaneously, consent may be best obtained by explaining your approach, describing the types of treatment methods you might like to use and setting the parameters within which you will work. If the patient consents to you proceeding on this basis, you may do so. If the patient becomes concerned that you are going outside the agreed parameters at any time during the consultation, you must stop the treatment.'

34. Save for a few drafting comments on guidance paragraph 15, it seems to have been well received. It provides a means for osteopaths to achieve valid consent without disrupting the flow of treatment. It was agreed that guidance paragraph 15 should remain in the document and be expanded upon with clear guidance on what constitutes valid consent.

35. A description of valid consent is given in the DoH guidance, which reads: 'For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question'. The DoH guidance goes on to explain how to assess capacity, what constitutes 'voluntary' and what information is sufficient for the person to be 'informed'.

36. *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* (published by the CHRE in January 2008), contains the following information about valid consent:

'Healthcare professionals must always ensure they have a patient's valid consent before carrying out any examination or investigation, and before providing treatment or care. They must also ensure they have ongoing consent from the patient where treatment changes or develops. For consent to be valid, patients must be given sufficient information, in a way that they can understand, to enable them to exercise their right to make informed decisions about their care.'

37. These definitions focus on the need for the patient to be informed. The guidance given at paragraphs 12 and 14 of standard A4 should be amended so the focus is moved away from 'distinct procedures' to the need to inform the patient appropriately on an ongoing basis.

38. The GOsC agrees that the standards and guidance set out in the OPS must reflect the law. This is a complex area of practice, which it also agrees should be supported by supplementary guidance. It was recognised that the legal requirements for seeking and receiving valid consent did not, at times, sit comfortably with osteopathic practice. The consultation responses had highlighted misunderstandings about the elements of valid consent, which needed to be clarified in the guidance that supported standard A4.

Explaining risks

39. Standard A3 requires osteopaths to 'give patients the information they need in a way that they can understand'. The guidance at paragraph 8 reads 'before examining or treating a patient, you should ensure that they understand: ... the risks involved in the treatment you propose to administer.'

40. Following the publication of the current *Code of Practice* in May 2005, osteopaths have expressed concern about the requirement to explain risks to their patients. Some considered this an unnecessary requirement that they should not have to meet. Others are concerned about the lack of quality information available for them to identify the risks and quantify them for their patients.

41. The requirement to explain risks is established by law. The DoH guidance provides a very useful summary of the recent developments in the law on consent for medical interventions. It acknowledges that 'while much of the case law relates to doctors, the same principles will apply to other healthcare practitioners involved in examining or treating patients'.

'The requirements of the legal duty to inform patients continues to develop in case law. In 1985, the House of Lords decided in the *Sidaway* case that the legal standard to be used when deciding whether adequate information had been given to a patient should be the same as that used when judging whether a doctor had been negligent in

their treatment or care of a patient: a doctor would not be considered negligent if their practice conformed to that of a responsible body of medical opinion held by practitioners skilled in the field in question. This is known as the 'Bolam test'. Whether the duty of care had been satisfied was therefore primarily a matter of medical opinion. However, *Sidaway* also stated that it was open to the courts to decide that information about a particular risk was so obviously necessary that it would be negligent not to provide it, even if a 'responsible body' of medical opinion would not have done so.

Since *Sidaway*, judgments in a number of negligence cases (relating both to the provision of information and to the standard of treatment given) have shown that courts are willing to be critical of a 'responsible body' of medical opinion. It is now clear that the courts will be the final arbiter of what constitutes responsible practice, although the standards set by the healthcare professions for their members will still be influential. In *Chester v Afshar*, a majority of the House of Lords held that a neurosurgeon who failed to warn a patient of the small risk of injury inherent in surgery, even if properly performed, was liable to the patient when that risk materialised, even though the risk was not increased by the failure to warn and the patient had not shown that she would never have had an operation carrying the same risk. The Lords departed from the traditional 'but for' test of causation on the basis that, exceptionally, policy and justice required a modification to causation principles. The fundamental principle underlying the decision was the right of a patient to make an informed choice as to whether – and if so, when and by whom – to be operated on.

In considering what information to provide, the health practitioner should try to ensure that the person is able to make an informed judgement on whether to give or withhold consent. Case law on this issue is evolving. It is therefore advisable to inform the person of any 'material' or 'significant' risks or unavoidable risks, even if small, in the proposed treatment; any alternatives to it; and the risks incurred by doing nothing. A Court of Appeal judgment stated that it will normally be the responsibility of the doctor to inform a patient of 'a significant risk which would affect the judgment of a reasonable patient' (*Pearce 1999*). Following *Chester v Afshar*, it is advisable that healthcare professionals give information about all significant possible adverse outcomes and make a record of the information given.

The GMC provides guidance on the type of information that patients may need to know before making a decision, and recommends that doctors should do their best to find out about patients' individual needs and priorities when providing information about treatment options. It advises that discussions should focus on the patient's 'individual

situation and risk to them' and sets out the importance of providing the information about the procedure and associated risks in a balanced way and checking that patients have understood the information given'[3].

42. It is very important that the *Code of Practice* for osteopaths reflects the current position on the law for consent. Standard A4 requires an osteopath to 'receive valid consent before examination and treatment'. This reflects the law. A key element of valid consent is that the consent is provided by an informed patient. For a patient to be informed, they must know the risks associated with the proposed treatment.

43. Although there was a limited patient response to the OPS consultation, the consultation report does take into account the views of osteopathic patients from the OPEn Project, September 2010. In relation to consent, the consultation report indentifies that patients expected:

    'the planned treatment to be explained in order for them to decide whether to proceed with treatment.'

    'osteopaths to recommend other treatments with other healthcare professionals if necessary and to be treated holistically.'

    '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.'

    'to have treatment risks pointed out to them if there were any.'

44. Osteopaths need to explain risks. The DoH guidance advises that a patient should be informed of any 'material' or 'significant' risks or 'unavoidable risks incurred by doing nothing'. The GMC advises that discussion should focus on the patient's 'individual situation and risk to them'.

45. Paragraph 8.3 simply states that an osteopath should explain 'the risks involved in the treatment you propose to administer'. This statement will be improved upon, as outlined in the agreed actions below.

[3] Department of Health, Reference guide to consent for examination or treatment – second edition, pages 12 and 13.

46. Another concern raised by osteopaths is that there is insufficient information available for them to be able to identify the risks. The *Chester v Afshar* case reinforced this requirement and was decided just prior to the publication of the current *Code of Practice* for osteopaths in 2005. A clause (clause 20) requiring osteopaths to explain risks to patients was included in the *Code of Practice* (2005) in response to the outcome of this case. This requirement caused significant concern and much debate about what was known about the risks of osteopathic treatment. It was recognised that the knowledge of risks and research available to identify risks was limited. As a result, the GOsC funded research to help identify the risks and put osteopaths in a better position to explain risks to their patients. The research is known as the 'Adverse Events Studies'. There are four projects under this research heading, which have reached different stages of development:

    a. Project 1: *Adverse events associated with physical interventions in osteopathy and relevant manual therapies.*

    b. Project 2: *Communicating risk and obtaining consent in osteopathic practice*.

    c. Project 3: *Insurance claim trends and patient complaints to the profession's regulator.*

    d. Project 4: *Investigating osteopaths' attitudes to managing and assessing risk in clinical settings and patients' experiences and responses to osteopathic treatment.*

47. The OPS must contain high-level information and guidance in this area which should clearly reflect the law. It is not practical for the OPS guidance to identify the risks associated with osteopathic treatment as the research is ongoing and the position may change. The GOsC, the National Council for Osteopathic Research (NCOR) and the British Osteopathic Association (BOA) have continually reported on the adverse events studies and their development. All three organisations should continue with this reporting. Osteopaths need to keep themselves informed of the relevant research on risks.

48. Given the complexities and anxiety around seeking valid consent from patients, the OPS should be supported by supplementary guidance. The GOsC has had early discussions with an osteopath who was involved in Project 1 about the possibility of producing user-friendly leaflets, one aimed at osteopaths and one aimed at patients, providing information on the currently-known risks associated with some of the techniques used by osteopaths. Thought must also be given to other ways of building the profession's knowledge and confidence for this element of practice.

Forms of consent

49. There is no specific guidance in the OPS to explain the different forms of consent. This has led to confusion, demonstrated by the following responses:

> 'GOsC should investigate and supply us with guidance on implied consent'.
>
> 'Guidance 16 & 17 – is this ongoing written consent?'
>
> 'A4 doesn't clarify whether verbal consent is sufficient; does it mean that this needs recording in patient's notes, that verbal consent given? Not practicable to keep gaining written consent...'
>
> 'Concerned that consent needs to be obtained for each specific procedure – this is unworkable. Does this mean written consent or oral consent? There is also the issue of implied versus explicit consent.'

50. Guidance should be included to explain that a patient may give their consent in different forms: implied, oral or written. Each of these forms is sufficient, provided the consent is valid (i.e. given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question).

51. The DoH guidance explains that:

> 'the validity of consent does not depend on the form in which it is given. Written consent merely serves as evidence of consent: if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not make the consent valid.'

This is a useful statement and one that may assist osteopaths to understand the status of written consent. In fitness to practise cases, osteopaths often present a form that was signed by a patient in the waiting room before they had seen the osteopath. This form usually contains words to the effect that the patient consents to osteopathic treatment and the osteopath thinks that by doing this, they have obtained valid consent from the patient.

52. The DoH guidance also explains that 'consent may be expressed verbally or non-verbally: an example of non-verbal consent would be where a person, after receiving appropriate information, holds out an arm for their blood pressure to be taken. However, the person must have understood what examination or treatment is intended, and why, for such consent to be valid.'

53. The General Chiropractic Council's Code of Practice emphasises that the 'informed patient' element of the consent process is more important than the form in which the consent is given: 'Before accepting a patient's consent, consideration should be given to whether the patient has been given the information they want or need and their understanding of what is proposed. This is more important than how they give their consent and how it is recorded. Patients can give consent orally, in writing or might imply consent by accepting or getting ready for the assessment or care.'

54. The General Medical Council's guidance on consent reads: 'Before accepting a patient's consent, you must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded. Patients can give consent orally or in writing, or they may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken.'

55. A paragraph should be added to the guidance to explain the different forms of consent and what part they play in the seeking consent process.

Agreed action:

a. That the OPS must reflect the law on consent.

b. Replace existing guidance at 8.3 of standard A3 with:

> **'You should inform your patient of any material or significant risks associated with the treatment you are proposing. If you are proposing no treatment, you should explain any risks associated with doing nothing. You should also explain any alternatives to the treatment. The information you provide should focus on the patient's individual situation and risk to them. You should check that the patient has understood the information you have given.'**

c. The guidance for standard A4 at paragraphs 11 to 15 to change to:

`For consent to be valid, it must be given:

- **voluntarily**
- **by an appropriately informed person**
- **with the capacity to consent to the intervention in question.**

The patient needs to understand the nature, purpose and risks of the examination or treatment proposed. The patient must then be free to either accept or refuse the proposed examination or treatment. Some patients may need time to reflect on what you have proposed before they give their consent to it.

Gaining consent is a fundamental part of your practice and is both an ethical and legal requirement. If you examine or treat a patient without their consent, you may face criminal, civil or GOsC proceedings.

Where your diagnostic examination and treatment are carried out simultaneously, consent may be best obtained by explaining your approach, describing the types of treatment methods you might like to use and setting the parameters within which you will work. If the patient consents to you proceeding on this basis, you may do so. If the patient expresses concern that you are going outside the agreed treatment plan, you must stop the treatment.

Before relying on a patient's consent, you should consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. This is more important than how their consent is expressed or recorded.

Patients can give consent orally or in writing, or they may imply consent by complying with the proposed examination or treatment, for example, or by getting ready for the assessment or care.

The validity of consent does not depend on the form in which it is given. Written consent may serve as evidence of consent but if the elements of voluntariness, appropriate information and capacity have not been satisfied, a signature on a form will not by itself make the consent valid.'

d. To produce supplementary guidance on consent to support that provided in the OPS document.

e. Consider supplementary guidance on risks and communicating risks as a result of the publication of the adverse events research.

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Consent for young people and children

56. Additional feedback suggested that further clarification of the guidance on consent for young people was required, specifically, in guidance paragraph 22, which supports standard A4. This issue was discussed by the OPS Working Group

57. To help explain the legal position for assessing the capacity to consent of a child under the age of 16, we have made reference (in paragraph 22) to a case that was decided in the English courts (*Gillick v West Norfolk and Wisbech AHA* [1986]). This is unhelpful as it does not explain clearly the position in the other UK countries. The guidance should, therefore, be amended so that it is applicable for all UK countries.

58. To assist with the drafting of the guidance, the GOsC referred to relevant legislation and the guidance provided by other healthcare regulators. It is recommended that the guidance at paragraphs 20 to 24 of the OPS document be amended.

59. While the guidance needs to be clear in the OPS, it can only touch the surface of this subject. It is intended to produce separate and more in-depth guidance on the wider subject of seeking consent. This guidance will provide more detail of the relevant areas of law that apply to each of the UK countries and seeking consent from children. References to this guidance will be made in the relevant sections of the Osteopathic Practice Standards.

Agreed action:

a. The guidance supporting standard A4 at paragraphs 20 to 24 should be changed to read:

`Before you examine or treat a child or young person, you should involve children and young people as much as possible in discussions about their care, even if they are not able to make decisions on their own.

Before you examine or treat a child or young person, you should ensure that you have valid consent. Obtaining consent for treatment to be given to a child or young person is a complex issue: the guidance given below is a summary only and provides advice on the more common scenarios that present in practice. You should refer to the more detailed advice in *Obtaining Consent*. Note that in the summary below, a 'child' is a person under the age of 16 years and a 'young person' is a person aged 16 or 17 years.

A child may have the capacity to consent, depending on their maturity and ability to understand what is involved. You will need to use your professional judgement in assessing the capacity of each patient under 16 years. You are strongly advised, wherever possible, to involve the child's parent when seeking consent.

If a child with capacity gives their consent to treatment, a parent cannot override that consent.

If a child lacks the capacity to consent, you should ask for their parent's consent to treatment.

A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing for them because, as with adults, consent must be valid (see above).

The position in relation to young people who lack capacity differs across the UK. In England, Wales and Northern Ireland, parents may in some circumstances be able to give consent to treatment for their 16 or 17 year old son or daughter without capacity, while in Scotland young people without capacity are treated in the same way as adults who lack capacity. You should refer to the further guidance in *Obtaining Consent*.

If a young person with capacity gives consent to treatment, that consent cannot be overridden by parents.

If a child or young person with capacity refuses treatment, that refusal may, in certain circumstances, be overridden. The need to override refusal of osteopathic treatment is likely to be rare, however, and in such an event you should refer to the advice in *Obtaining Consent* and/or seek legal advice.'

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The use of the word 'diagnosis'

60. One of the main findings from the consultation analysis report is as follows:

> 'Almost all of those who commented on C1 remarked on the use and application of the word 'diagnosis' in the osteopathic context, and on the subsequent treatment plan required. Some very detailed recommendations were submitted, with a number of respondents suggesting the inclusion of the phrases 'working hypothesis', or 'osteopathic evaluation'.

61. The following quote gives additional comment:

> *'...in many cases it is not possible to make a definitive diagnosis as further investigations or a trial of treatment are necessary in order to clarify the situation'.'*

62. This particular section caused a lot of discussion, so it is important to represent the viewpoint of osteopaths which is captured by a number of detailed quotes outlined below:

a. **'Diagnosis and evaluation**

I don't have a major problem with the standards in the OPS in this regard but I don't feel that they reflect the nature of osteopathic practice as well as they might and I think there is an opportunity here to make a positive step in making it clearer what osteopaths do in practice. The relevant standards are C1 (1.5), which requires the ability to "formulate appropriate diagnostic hypotheses to explain the patient's presenting complaint and, through a process of deduction, select the most likely diagnosis" and C7 (14.3), which states that "providing appropriate care and treatment includes [...] formulating a diagnosis and treatment plan."

The wording in these standards fails to reflect the distinction between a diagnosis, which involves determining what kind of condition the patient has (i.e. ascribing a category), and making an osteopathic evaluation, which involves determining the mechanical, physiological and psychological elements of that condition and where osteopathic treatment may be able to influence these (i.e. coming to a holistic understanding). This is an important distinction in osteopathic practice as the former is the basis of our triage process and hence important in ensuring patient safety, whilst the latter forms the basis of our treatment plan.

I would like to see the diagnosis and osteopathic evaluation more clearly distinguished along these lines and perhaps the osteopathic evaluation could be more fully expanded to include such elements as recognising the predisposing, maintaining and precipitating factors and appreciating the relationship between the mechanics, the physiology and the psychology contributing to the condition.'

b. 'Clinical practice is often marked by uncertainty and in many cases it is not possible to make a definitive diagnosis as further investigations or a trial of treatment are necessary in order to clarify the situation. Hence requiring a diagnosis is an impossible standard for osteopaths to consistently attain. The focus should be placed instead on conducting a sufficient diagnostic evaluation to determine the most appropriate course of action.

In addition, there is a wide diversity of opinion about what constitutes an osteopathic diagnosis. Whilst a diagnosis is commonly thought of as a category of disease, in the osteopathic model the focus is on an explanation of the unique factors which have led to the patient's dysfunction, as this is what is necessary in order to tailor a treatment plan to their individual needs. This more commonly takes a narrative form which explains the patient's symptoms in terms of the multiple mechanical, physiological and psycho-social factors that may be contributing to them and places these in the wider context of their life.

Any ambiguity about this in the standards could lead to unfairly prejudicial judgements being made about the safety of an osteopath's practice on the basis of misplaced assumptions about the nature of osteopathic diagnosis, especially if their practice is being evaluated by non-osteopaths as would occur in the event that osteopathic regulation were to come under the HPC.

For this reason, it is essential that the standards leave no room for misinterpretation here. They must be flexible enough to allow for a diversity of approaches whilst still establishing clearly what is necessary for safe practice. This can best be accomplished by shifting the focus from the diagnosis itself to the process of making an evaluation, which is far more important for patient safety. This process involves two parallel activities:

1. The determination of whether the patient needs referral for further investigations or other treatment (covered in C7, 14.5, C2, 2.4 & C2, 2.8)
2. The generation of a hypothesis as to the nature of the patient's condition and the unique factors that have led to their dysfunction, which must be sufficient to form the basis of a safe and effective treatment and management plan

The standard should therefore be changed to: "*You must be able to conduct a sufficient diagnostic evaluation to inform your clinical decisions"* and the guidance should clarify the kinds of judgements that must be made in order to accomplish this without being too prescriptive about how.'

c. "Appropriate clinical investigations for your patient" implies that there is a correct procedure for every presentation. However, practitioners with more clinical experience and palpatory ability often dispense with certain more formal clinical investigations as they are able to obtain the necessary information without them and, having first excluded the need for urgent referral, many osteopaths use treatment as their primary diagnostic tool. Hence, in order to allow for flexibility in the approach taken, this should be changed to "conduct a sufficient examination to inform your clinical decisions".

d. 'As discussed above, osteopathic diagnostic evaluation is not so much a question of selecting one diagnosis from a range of hypotheses as coming to understand how the patient's unique history and circumstances have led to their dysfunction whilst, in parallel, establishing if there is a need for referral for other treatment or further investigation. Point 1.5 is completely inadequate to the purpose of characterizing this process and should be replaced by two separate points describing each of these aspects:

   • 1.5 evaluate the need for referral for further investigation or other treatment.
   • 1.6 generate a plausible hypothesis as to the nature of the patient's condition encompassing the unique factors that predisposing, exciting and maintaining their dysfunction'

e. 'Standard C1 – Rearrange wording to: 'You must be able to conduct an osteopathic patient evaluation sufficiently to make a diagnosis and formulate a treatment plan".

f. 'Standard C1 guidance 1.5 - Currently implies diagnosis is more important than clinical reasoning therefore change to: 'Be able to demonstrate the reasoning which underpins the working diagnosis"

g. 'You might not have a diagnosis. You have to have an ability to work without a diagnosis, would work with a 'working hypothosis'. It is about forming an osteopathic evaluation to form basis of a treatment plan under continuous review.'

h. ‘The wording in these standards fails to reflect the distinction between a diagnosis, which involves determining what kind of condition the patient has (i.e. ascribing a category), and making an osteopathic evaluation, which involves determining the mechanical, physiological and psychological elements of that condition and where osteopathic treatment may be able to influence these (i.e. coming to a holistic understanding). This is an important distinction in osteopathic practice as the former is the basis of our triage process and hence important in ensuring patient safety, whilst the latter forms the basis of our treatment plan.’

i. ‘Section C, standard C1. The standard here refers to a single diagnosis. We suggest that this standard and the related guidance favours a model of medical decision making that is not supported by current evidence and fails to sufficiently acknowledge the uncertainty that is likely to face practitioners working in the field of osteopathy. There may well be several competing interpretations of a clinical scenario and an individual practitioner may work with these in an effective and safe manner. We recognise the value and role of analytical processes such hypothesis testing and deduction in clinical reasoning, but also suggest that this type of reasoning is one of many strategies used by practitioners. Non analytical strategies such as pattern recognition are associated with experience and expertise and to assume that deduction alone is used is an incorrect assumption. At the minimum we suggest that C1 should be amended to "You must be able to conduct a sufficient osteopathic patient examination to formulate a working diagnosis or evaluation." We note the use of the wording working diagnosis in Section C 16.7. The final part of the C1 standard seems superfluous as it is not addressed in the guidance and appears more clearly articulated in C2.’

j. ‘Part C2 - diagnostic reasoning is more explicit and communicable. However, how DO osteos make decisions during the ongoing patient encounter. All the literature (almost all older textbooks) informs how osteos SHOULD reason, rather than how we ACTUALLY reason. There seems to be a lack of provision for the concepts of osteopathy; in particular, what an osteopathic evaluation of a patient entails and how this differs from a "diagnosis" - which seems to be more emphasised in the document. A diagnosis, or working hypothesis, is, of course, important, but does not form the full basis of a treatment plan - in fact in some cases the "diagnosed" tissue is not directly treated at all. For example, section C2.2 implies that the osteopath's "justifiable" course of action should be based on: diagnosis; personal limits of competence; and likely effects of treatment - but no mention of overall evaluation, i.e. predisposing or maintaining factors, health beliefs, psychological status etc. which most certainly should have a bearing on treatment plan or course of action deemed most appropriate. For instance, under these guidelines it may be hard to justify a rhythmic soft tissue technique applied to a patients thorax in the case of a diagnosis of tendinosis of the elbow unless you take into account the nervous, highly- strung disposition of the patient and the role of this technique choice has in establishing a state of relaxation and trust with the patient, giving them time and space to talk, and therefore making them amenable to further and perhaps more direct forms of treatment - as

well as the beneficial effect of therapeutic touch on the patient's wellbeing as a whole and how this is likely to facilitate a better state for healing to take place.'

k. 'Osteopaths don't treat conditions we treat patients who have conditions and our aim as osteopaths is to help their bodies to function as well as they can. Treating a patient with an incurable disease can help that patient's quality of life, be it cancer, RA, HIV or whatever.'

l. 'C1 '...make a diagnosis...' Often one initially is assessing, examining and then deciding on the 'best practise '...with perhaps the thought of one of several possible differential diagnosis. It is perhaps rather naive and prescriptive to force a diagnosis too early on.'

m. 'The section on diagnosis and treatment needs to be enlarged to take account of the differences in osteopathic processes and protocols compared with other healthcare professionals'.

n. 'How do you define "diagnosis"? Could be the label of a syndrome, or description of where/how a patient is at the time of the appointment - not always possible to form a diagnosis. Could form a hypothesis which is evolving and may change the "diagnosis" and treatment.'

63. Whilst this was the views of osteopaths, the feedback from the patients' organisation that responded was:

a. *'Diagnostic hypotheses C1: this may reflect the nature of the diagnostic process in osteopathy, but the wording of guidance note 1.5 came across as somewhat woolly'.*

Discussion

64. It is important to take account of the view of osteopaths in this matter, but to appreciate that the language used must be clear to patients and external audiences. Diagnosis is a term that is recognised and understood by the patients to mean what a healthcare practitioner considers to be the problem and forms the basis for treatment.

65. A patient will expect to be evaluated, be told what the problem is likely to be and be treated (or referred) accordingly. As indicated in the quote from the patient organisation, it is unlikely that a patient will appreciate the nuances in whether their condition has been 'diagnosed' or has been the most likely hypothesis in an 'osteopathic evaluation'.

66. The GOsC considered whether it felt the use of the term 'diagnosis' in this context was inappropriate. If diagnosis was restricted to a 'medical diagnosis' where a specific condition is identified and treated, then it would be inappropriate for use here.

67. In the Code of Practice/Standard of Proficiency

68. for chiropractors it states that chiropractic is:

    a. 'A health profession concerned with the diagnosis, treatment and prevention of mechanical disorders of the musculoskeletal system, and the effects of these disorders on the functions of the nervous system and general health. There is an emphasis on manual treatments including spinal adjustment and other joint and soft-tissue manipulation.' WFC Dictionary Definition, World Federation of Chiropractic, 2001.

69. The GOsC could remove diagnosis from both the standards and the guidance and replace with 'osteopathic evaluation'. This would have the benefit of addressing the concerns raised by osteopaths. However, this would downgrade the status of an osteopath as a primary care practitioner with the right to diagnose.

70. The GOsC does not consider diagnosis to be limited to 'medical diagnosis' and could be used in the osteopathic context.

71. The GOsC could also expand the definition of 'diagnosis' within the guidance so that it covers both a specific diagnosis and a working diagnosis, which could later be modified following further examination or treatment. This has the benefit of retaining a clear meaning for the patient whilst appreciating the need to allow flexibility for the osteopath in reaching conclusions. The term 'working diagnosis' could replace 'diagnosis'.

72. This is the approach taken in the Standard and Code for the chiropractors as follows:

    'Clinical decision making
    You must:
    a) evaluate the patient's health and health needs
    b) arrive at and document a working diagnosis or rationale for care, based on the evaluation of the information.

    When drawing up the working diagnosis or rationale for care, you must consider:

a) relevant information about the natural history and prognosis of any complaint the patient has
b) the potential benefits and risks of care, including contraindications
c) the likelihood of recurrence or need for long-term management.

You must keep the working diagnosis or rationale for care under review while you care for the patient.'

73. Valid points had been made that suggest the term 'diagnosis' was not accurate. It was agreed that the term 'working diagnosis' more accurately reflected an osteopath's approach.

Agreed action:

a. **The term 'diagnosis' should be replaced with 'working diagnosis' in standards C1, C2 and C7.**

b. **The guidance provided at C1.5 should be changed to read: 'formulate appropriate diagnostic hypotheses to explain the patient's presenting complaint and using your osteopathic skills develop a working diagnosis.'**

c. **The term 'will' used in the guidance provided at standard C2 should be replaced with 'should'.**

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Upholding the reputation of the profession through your conduct

74. Standard D17 requires a registrant to 'uphold the reputation of the profession through your conduct'. The guidance, at paragraphs 38 and 39, explains that this includes professional and personal conduct and gives examples of the types of conduct expected of a professional. Guidance paragraph 40 requires osteopaths to notify the GOsC if:

'a. they are charged with a criminal offence
b. civil proceedings are issued against them in relation to their practice of osteopathy
c. they are subject to any investigation or adverse decision by a professional body whether in healthcare or otherwise.'

75. Osteopaths expressed concern that this standard went too far and it was considered by some to be irrelevant to patient safety or clinical care. It was suggested that it left osteopaths vulnerable to abuses of regulatory power. Some held the view that the standards should not encroach on the registrants' personal lives and that it should be removed or replaced with, for example, 'act responsibly in all areas if your professional life'. In particular, the British Osteopathic Association (BOA) made reference to this standard in its response as an example of what it calls 'regulatory creep':

'Standard D17 – Yet more evidence of regulatory 'creep' there must be a real break between professional and private life.'

Guidance paragraph 39

76. Concern was also raised about the guidance provided in this paragraph. Some suggested that all references to 'personal life' should be removed and that the guidance should focus only on professional life. One of the osteopath focus groups was concerned that the guidance provided at paragraph 39 did not provide a full list of possible circumstances that may be relevant to the standard. It suggested including a phrase about having regard to one's professional standing when not acting as an osteopath. Others sought clarification on what constituted 'abuse of drugs or alcohol'.

77. The list provided in the guidance could never be exhaustive. It currently provides a good guide to the areas that are likely to be seen as bringing the profession into disrepute. It does, however, seem sensible to add a sentence addressing the point raised about having regard to one's professional standing even when you are not acting as an osteopath.

78. Others were concerned about the guidance provided at 39.3, which reads 'upholding the reputation of the profession includes…not behaving in an aggressive or violent way in your personal or professional life'. The concern was that participating in certain sports could be considered violent and/or aggressive behaviour.

Guidance paragraph 40

79. Concern was raised about the guidance provided at paragraph 40. Many thought that it was unreasonable to ask osteopaths to notify the GOsC when a civil claim was made against them. It was considered disproportionate and it was pointed out that this is not a requirement that other regulators place on their registrants. It was also suggested that the GOsC should recognise that sometimes trust can break down between a patient and practitioner and that practitioners can make mistakes, which were genuine errors and not malpractice.

80. Others thought that it went too far to suggest that osteopaths should advise the GOsC when they have been charged with a criminal offence. Many seemed to accept that it was reasonable for an osteopath to notify the GOsC when they had been convicted of a criminal offence, although some would like the guidance to specify the types of offences that should be reported.

Discussion

81. It is not unusual for a Code of Practice to include requirements on professionalism and the need to avoid conduct that may bring a profession into disrepute. For example:

    a. Good Medical Practice for doctors contains a section on probity, which explains that being honest and trustworthy, and acting with integrity, is at the heart of medical professionalism. It states that doctors 'must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession.'
    b. The Nursing and Midwifery Council publishes a Code of Practice that requires nurses to 'Be open and honest, act with integrity and uphold the reputation of your profession'.
    c. The Code of Practice published by the General Chiropractic Council includes a standard that chiropractors 'must avoid acting in a way that may undermine public confidence in the chiropractic profession or bring the profession into disrepute.'
    d. The Code of Practice published by the Health Professions Council requires that registrants 'must keep high standards of personal conduct, as well a professional conduct. You should be aware that poor conduct outside your professional life may still affect someone's confidence in you and your profession.'

82. A standard that requires osteopaths to uphold the reputation of their profession through their conduct is not out of step with the requirements placed on other healthcare professionals. It is widely accepted that a professional's personal conduct may undermine public confidence in his/her profession. Generally, conduct relating to dishonesty, violence, indecency and drug or alcohol abuse may be considered relevant.

83. The guidance supporting standard D17 should show that an individual's personal conduct can have an impact on their professional life. The guidance provides some examples but not an exhaustive list. In relation to guidance 39.3, proper conduct during sports events would not bring the profession into disrepute. Unreasonable or unnecessary aggression or violence during competitive sports may do so.

84. The requirements that osteopaths notify the GOsC that they have been charged with, rather than convicted of, a criminal offence is new. Otherwise, the current *Code of Practice* for osteopaths (published May 2005) contains the same requirements that are set out

in paragraph 40 of the guidance. Some, but not all, of the other healthcare regulators require their registrants to provide similar information to that requested in paragraph 40. For example:

a. The GMC requires doctors to 'inform the GMC without delay if, anywhere in the world, you have accepted a caution, been charged with or found guilty of a criminal offence, or if another professional body has made a finding against your registration as a result of fitness to practise procedures.'

b. The NMC requires nurses to 'inform the NMC if you have been cautioned, charged or found guilty of a criminal offence.'

c. The HPC requires registrants to 'provide (to us and any other relevant regulators) any important information about your conduct and competence… In particular, you must let us know straight away if you are: convicted of a criminal offence, receive a conditional discharge for an offence, or if you accept a police caution; disciplined by any organisation responsible for regulating or licensing a healthcare or social-care profession; or suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.'

85. Guidance paragraph 40 needs review. It does not sit comfortably as guidance, because it is drafted as a 'must' rather than a 'should'. The requirements placed on osteopaths are not dissimilar to the requirements placed on other healthcare professionals but we consider that if the GOsC wishes to be notified of the events listed in paragraph 40, then this requirement should become a standard. The requirements are to notify on civil and criminal proceedings

Civil proceedings

86. The requirement to notify the regulator of civil claims is not something that appears in other health professions' codes of practice. It is, however, a requirement of the current *Code of Practice* for osteopaths. Osteopaths are also required to declare this information on their annual renewal of registration form. The reason for seeking this information is to allow the GOsC to recognise when an osteopath may be subject to a high proportion of civil claims, which may raise concerns about their competence and lead to a fitness to practise investigation, although in practice there has never been such an investigation as a result of this requirement. Some regulators, such as the Health Professions Council (HPC), require registrants to notify them if they 'are suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.'

87. The consultation responses showed strong opposition to such a requirement. As a high proportion of osteopaths are self-employed, the GOsC could not rely on an employer to take action or notify the GOsC if a high proportion of claims were made against one

osteopath. However, the GOsC is able to collect information on an annual basis about relevant civil proceedings via the registration renewal forms. Since it is likely to be the pattern of claims, rather than a 'one-off' incident which would cause us concern, this is sufficient notification for the Regulation Department to consider fitness to practise proceedings.

88. It was agreed that the requirement to report civil proceedings should be removed.

Criminal charges

89. The requirement that osteopaths notify the GOsC if they have been charged with a criminal offence is new. Currently, osteopaths are required to notify the GOsC if they have been convicted of a criminal offence. Some, but not all, healthcare regulators require registrants to notify the regulator when charged (e.g. GMC and NMC). The GOsC wishes to be notified when an osteopath has been charged with a criminal offence so that, where necessary, it is able to take immediate fitness to practise steps to protect members of the public. As these immediate steps will relate to the most serious of allegations, it is possible to specify the types of charges that are to be reported to the GOsC.

90. It was agreed that some aspects of a professional's personal life will impact on their professional life and the guidance provided in the OPS should, therefore, properly reflect this. Some thought should be given to communicating this to the profession.

91. It was agreed that it was appropriate for an osteopath to provide important information about their conduct and competence to the GOsC, as outlined at paragraph 40, and that this should be reflected in a standard, rather than guidance. It was agreed that the 'important information' included:

'a. being charged with an offence, anywhere in the world, relating to:
   i. Violence
   ii. Sexual offences or indecency
   iii. Dishonesty
   iv. Alcohol or drug abuse
b. being convicted of a criminal offence, anywhere in the world
c. receiving a conditional discharge for an offence
d. accepting a police caution
e. being disciplined by any organisation responsible for regulating or licensing a healthcare profession

f. being suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.'

Agreed action:

a. **Standard D17 should remain as currently drafted.**

b. **The D17 guidance at paragraphs 38 and 39 should remain as drafted with additional reference in the guidance to the inappropriate use of internet sites, particularly social networking sites, which may impact on an osteopath's professional life.**

c. **An additional sentence should be added at guidance paragraph 38 to read 'You should have regard to your professional standing, even when you are not acting as an osteopath.'**

d. **Paragraph 40 should be removed.**

e. **A new standard D18 should be included to read 'You must provide to the GOsC any important information about your conduct and competence.'**

f. **The guidance supporting stnadrd D18 to read:**

'You should tell the GOsC, straight away, if you:

i. are charged with an offence, anywhere in the world, relating to:
- **violence**
- **sexual offences or indecency**
- **dishonesty**
- **alcohol or drug abuse.**

ii. are convicted of a criminal offence, anywhere in the world.

iii. receive a conditional discharge for an offence.

iv. accept a police caution.

v. are disciplined by any organisation responsible for regulating or licensing a healthcare profession

vi. are suspended or placed under a practice restriction by an employer or similar organisation because of concerns about your conduct or competence.'

g. To remove the requirement to submit any information on civil proceedings from D17 guidance paragraph 40.

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Modesty

92. The consultation analysis indicates that concerns were raised by osteopaths on the guidance provided on modesty, which can be found under standard C6, guidance 7 to 10. These are summarised in the report as:

> 'Everyone appeared to wish to respect cultural/religious beliefs, but many felt that in order to provide a 'best quality treatment' they did need to see the patient undressed and they found covering them up during treatment a hindrance to this. They felt that this guidance worked against the fundamentally holistic nature of osteopathy. Others talked about the ridiculousness and cost (initial outlay for suitable covers, ongoing laundry etc) of this, whilst others appeared to have no issues with it at all, and many commented that patients were also responsible for saying if they were uncomfortable.'

93. One osteopath explained in the report:

> 'C6, point 8.2. This is too prescriptive. Much clinically useful information can be gleaned from observing a patient get dressed/undressed and this is partly dependent on their being unaware that one is critically observing them so explaining why one wishes to observe them somewhat defeats the purpose. The important point is to give the patient the option of changing in private. E.g. add "…if they wish".'

94. Another osteopath explained that:

> **'Covering up ...** clause 8.5 advises "ensuring that patients are only undressed to the level needed for the procedures being used at any given stage of the consultation and not left undressed for longer than necessary." This is rather prescriptive and could be problematic for those who work with a whole body approach in which the flow of the treatment is seen as just as important a contribution to the therapeutic benefit as the individual techniques.

Continually stopping to move covers around may compromise both the flow of the treatment and the osteopath's ability to judge the effect that treatment is having on the patient's overall posture and bodily coordination.'

95. Some osteopaths made a request for a definition of 'intimate areas' to be provided at C6 guidance paragraph 9. Others suggested that the words 'intimate areas' were superfluous. It was also suggested that patients should be 'encouraged' to put their underwear back on rather than being 'allowed' to. Others suggested that C6 guidance paragraphs 9 and 10 should be merged.

Discussion

96. The concerns raised relate to the guidance that is provided at paragraphs 7 to 8 of standard C6. The relevant standard (C6 – respect your patients' dignity and modesty) appears to be acceptable. The concerns about the guidance fall into the following categories:

Observing patients as they dress and undress

97. Some osteopaths wish to observe patients while they dress and undress to glean useful clinical information. It is suggested that it is not practicable to seek agreement from the patient before observing them in this way as this will cause the patient to act in an unnatural manner.

98. This method of practice carries a great risk for the osteopath. Patients become concerned when observed in this way. These concerns grow as the appointment continues and can lead to complaints being made about the osteopath. The complaints will commonly fall into a sexual boundary allegation.

99. Feedback from the OEIs questioned why the guidance at 8.3 had been provided:

'Observing patients undressing. Felt it was strange to put this in. It may be useful for an osteopath to observe this, but not essential. So do not see the need for it to be in the guidance, particularly as the section on modesty really covers it'.

100. Although a student response felt: 'Despite the relevant points about patient modesty, there is some advantage of staying in a room whilst a patient undresses to see the severity of the problem, and see their limitations.'

101. Guidance given in relation to the treatment of intimate areas in the CHRE's publication *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* (June 2008), provides the following comment:

> 'there should be a place to undress, such as a curtained space or changing room, that is out of view of anyone else, including the healthcare professional, other employees, patients and the public, unless observation is necessary as part of a clinical assessment and the patient understands and consents to this'.

102. Although this guidance is given in relation to intimate areas it should apply to the osteopathic setting. Most osteopathy patients will need to undress to their underwear for an examination and they should be able to undress in private, if they wish. If they feel they are being observed undressing and do not understand the reasons why this may be the case, they will become concerned.

103. Some osteopaths appear to have found a way to glean the relevant clinical data needed, without having to observe their patients dressing and undressing. An OEI suggested that the practice of watching patients undress might be useful but that it is not essential. It was agreed that the guidance at C6, paragraph 8.2 and 8.3 is achievable and should remain.

Paragraphs 8.4 and 8.5

104. It has been suggested that paragraphs 8.4 and 8.5 should be merged as they essentially amount to the same thing. Concern has been raised about the guidance in paragraph 8.5 that on a literal reading, you could imagine a patient constantly putting clothing on and off throughout the consultation. The essence here is that a patient can protect their modesty as far as possible. Rewording of paragraphs 8.4 and 8.5 could achieve this.

Intimate areas

105. It has been suggested that the words 'intimate area' in C6 paragraph 9 are superfluous. This is accepted and these words should be removed.

106. It was also suggested that patients should be 'encouraged' to put their underwear back on rather than being 'allowed' to and that paragraphs 9 and 10 should be merged.

107. The guidance at paragraph 9 is intended to inform osteopaths that, when a patient has removed underwear (bra or pants) for a specific treatment, then the patient should put this underwear back on at the earliest opportunity. Osteopaths should allow patients

the opportunity to put their underwear back and, if that opportunity is not taken by the patient, should encourage the patient to do so. Changing the word 'allow' to 'encourage' does indicate more strongly that the patient should put their underwear back on.

108. Paragraph 10 does provide guidance on a slightly different point to that contained in guidance 9. Whilst the guidance in both paragraphs relates to the removal of underwear, paragraph 9 deals with the length of time the underwear is removed for and paragraph 10 deals with who should remove it. Paragraphs 9 and 10 should remain as separate paragraphs as this provides clarity to the different advice being given.

Agreed Action

a. The term 'undressed' should be explained in the glossary to the document.

b. The guidance at C6 paragraph 8.2 should remain.

c. The guidance at C6 paragraph 8.3 should remain and be amended to read:

'explaining why (if you consider it necessary or helpful for the purposes of diagnosis or treatment) you wish to observe them undressing. If the patient is unhappy about that, you should respect their wishes and find another way of establishing the clinical information you need'.

d. The guidance at C6 paragraphs 8.4 and 8.5 be removed and replaced with:

'Covering the parts of their body that do not need to be exposed for the examination or treatment. This can be achieved by providing the patient with an appropriate cover or allowing them to remain partially dressed. If you need to see the patient undressed to their underwear, you should explain this to the patient and ask them if they are comfortable with remaining uncovered.'

e. The guidance at C6 paragraphs 9 and 10 should remain as separate paragraphs.

f. The guidance at C6 paragraph 9 should be amended to read:

'If you need your patient to remove underwear for an examination or treatment, you should encourage them to put their underwear back on at the conclusion of that particular examination or treatment, and before you continue with any other procedure.'

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Intimate areas

109. Concerns were raised on the examination and treatment of intimate areas. The concerns related to the advice to delay the procedure to a later appointment, the list of intimate areas and when written consent was required. The relevant guidance could be found in the consultation document at:

A2 guidance paragraphs 6 and 7 – communication.
A2 guidance paragraphs 16 and 17 - seeking consent.
C6 guidance paragraphs 9 and 10 - respecting patients' dignity and modesty.

110. The intimate nature of osteopathic treatment can come as a surprise to some patients. These patients can become concerned at the level of undress required, the observation of their movements whilst undressed and the gentle palpation of their body. When the examination or treatment moves to a particularly intimate area, such as the groin or pelvis, the patient's anxiety can increase. Patients do not generally expect an osteopath to propose an internal (vaginal or rectal) examination or treatment. Osteopaths must recognise this and the risk for them if they do not communicate their proposed approach and the reasons for that approach clearly and effectively to patients.

A2 guidance paragraphs 6 and 7

Written consent

111. Some confusion has been created by the guidance at A2 paragraph 6, when compared to the guidance at A4 paragraph 17, which advises written consent for vaginal and rectal examinations and techniques. Concern was also raised about the word 'sure' in the sentence that reads 'when you are sure the patient understands what you have said, ask whether they agreed to the procedure.'

112. As with other guidance about seeking and receiving consent, there appears to be some confusion about the different forms by which a patient can provide their valid consent.

113. Paragraph 6 should be revised as should the advice to receive consent in the written form for intimate areas, which is provided in A4 paragraph 17. The guidance given by the Department of Health in its second edition of *Reference guide to consent for examination or treatment* says that it is 'good practice to obtain written consent for any significant procedure'. Vaginal and rectal procedures can be considered significant and osteopaths should be strongly advised to ask the patient to provide their consent in the written form. Whether the osteopath asks the patient to provide their consent in the written form for the examination or treatment of other intimate areas should be left to the osteopath's judgement. The guidance at A2 paragraph 6 and A4 paragraph 17 will be changed to reflect this.

Delaying the procedure

114. Many osteopaths have expressed concern that the guidance at A2 paragraph 7 advises that 'when proposing to undertake any vaginal or rectal examination or technique, you should schedule the procedure for another appointment'. This is considered unnecessary, particularly when the patient has been referred to the osteopath specifically to be treated in this way. Also, it was suggested that this would be impracticable for the patient, incur extra costs and might create unnecessary anxiety for the patient. Many suggested that this should be changed to read the osteopath 'should offer to reschedule the procedure for another appointment'.

115. A2 guidance paragraph 7 advises that when an osteopath is proposing to undertake a vaginal or rectal examination or technique, they should schedule the procedure for another appointment. Patients may not expect this treatment from an osteopath and can be surprised and unprepared for the procedure. The purpose of this advice is to allow the patient time to consent and prepare. Consent and preparedness should not present significant difficulties when the patient has been referred to an osteopath for this specific procedure.

116. If osteopaths feel that they are prevented from ever carrying out these procedures at the appointment at which they are first proposed, and that there is no discretion, patients may suffer. Patients who are prepared and do not feel the need for more time to consider the appointment may incur the inconvenience and additional cost of having to return for a second appointment for the procedure. Others may be left in some pain because the osteopath is fearful of proceeding immediately and insists on delaying the procedure to another time.

117. What is important is that the patient has the option, and feels able, to delay the procedure to another appointment if they wish. A clear offer of delaying the procedure to another appointment should be made and the patient should feel free to choose if and when the procedure is undertaken. The guidance at A2 paragraph 7 will be changed to reflect this.

A4 guidance paragraphs 16 and 17

List of intimate areas

118. A4 guidance paragraph 16 explains that 'intimate areas include the mouth, groin, pubis, perineum, breast and anus, but this list is not exhaustive. Some patients may regard other areas of their body as 'intimate'. Some osteopaths have suggested that an exhaustive and definitive list of intimate areas should be provided so that it is clear what is considered 'intimate' and what is not. It was suggested that the absence of an exhaustive list leaves osteopaths vulnerable. Others have suggested that the mouth is not an intimate area. Another osteopath thought that the inclusion of any list was inappropriate, and was suggested that:

> 'This is guidance which is proposed to be referred to in a court with civil standard of proof. The law of the Normalisation of Aberrance states that the list will grow and become totally unworkable, so that in time osteopaths will not treat patients as they should. Patient care will suffer on the altar of defensive medicine. This clause needs a great deal of consultation with a range of osteopaths to become more workable and specific.'

119. In preparing the guidance, the GOsC had regard to the CHRE's publication *Clear sexual boundaries between healthcare professional and patients: responsibilities of healthcare professions* (June 2008). Whilst the focus of this guidance is on the maintenance of clear boundaries, it makes reference to standards of professional conduct that apply to relationships between healthcare professionals and patients. The following statements are made:

> 'Acknowledging differences
> Cultural differences can affect people's perceptions of what is intimate or appropriate. For example, some patients may be modest about showing parts of the body that their healthcare professional would not usually consider to be intimate. Healthcare professionals must be sensitive to cultural difference and treat patients in a way that respects their views and wishes, and preserves their dignity.'
>
> 'Intimate examinations

The definition of an intimate examination will depend on the patient's perspective and may be affected by cultural issues. Healthcare professionals must be aware of this and ensure that patients' privacy and dignity are maintained.'

120. It is not possible to provide an exhaustive list of intimate areas. The list highlights the areas that most patients are likely to consider intimate. It is a useful guide that alerts an osteopath to the need for clear and effective communication when examining or treating these areas. The list should remain, although the examination or treatment of the mouth could be removed, particularly as this list is used to define when a chaperone should be offered.

121. A4 guidance paragraph 17 was thought by some to be unclear in terms of when consent should be given in the written form. Others thought it was unnecessary to receive written consent for treatment of the groin and pubis. It was also suggested that paragraphs 16 and 17 duplicated the same advice.

C6 guidance paragraphs 9 and 10

122. Some made a request for a definition of 'intimate areas' to be provided at paragraph 9. Others suggested that the words 'intimate areas' were superfluous. It was also suggested that patients should be 'encouraged' to put their underwear back on rather than being 'allowed' to. Others suggested that paragraphs 9 and 10 should be merged.

123. The guidance in paragraph 9 supports the standard that requires osteopaths to 'respect your patients' dignity and modesty'. It has been suggested that the words 'intimate area' in this paragraph are superfluous. This is accepted and these words will be removed.

124. The discussion about whether a patient should be 'allowed' or 'encouraged' to put their underwear back on is contained in the section on Modesty.

Agreed action:

a. **The guidance at A2 paragraph 6 to be replaced with 'Good communication is especially important when you have to examine or treat intimate areas. You should first ensure you explain to the patient clearly and carefully what you need to do and why you need to do it. The patient needs to understand the nature and purpose of the**

examination or treatment proposed. Intimate areas include the groin, pubis, perineum, breast and anus, but this list is not exhaustive.'

b. The guidance at A2 paragraph 7 to be replaced with 'When proposing to undertake a vaginal or rectal examination or technique, you should offer to conduct the procedure at a subsequent appointment. Some patients may not expect you to propose these procedures and may not have come prepared for such a procedure, and may prefer to return at another time.´

c. The word 'mouth' to be removed from the list of intimate areas provided in A4 guidance paragraph 16.

d. The wording of the guidance at A4 paragraph 17 to be changed to 'When proposing a vaginal or rectal examination or technique, you should ask the patient to provide their consent in the written form, by signing a consent form. This form should be placed on the patient's records. You may also ask patients to provide their consent in the written form for other procedures.'

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Chaperones

125. The consultation analysis report explains that the guidance on chaperones (C6 guidance 11 to 13) led to considerable debate and variance of interpretation. This is summarised in the report as:

> 'The offer/provision/use of chaperones and interpreters also led to considerable debate and variance of interpretation. Many understood what was stated as meaning the osteopath had to make this provision, and they expressed considerable concern about their ability to do this and the cost of doing so. Reference was made several times about the issues particularly for sole practitioners and also home visits. We also had considered the issue (as did some respondents) of the safety of the osteopath in these situations, and what precautions they may need to consider/take.'

126. This was supported by the following quote:

> '*This creates a potential risk to the osteopath if couples are trying to set osteopaths up.´*

Discussion

127. The concerns raised relate to the guidance that is provided at C6 paragraphs 11 to 13. The relevant standard (C6 – respect your patients' dignity and modesty) appears to be acceptable.

128. The guidance given at paragraphs 11 to 13 mirrors that which is provided in the current *Code of Practice* (May 2005). It is important for a patient to be able to be accompanied during their consultation, if they wish. In particular circumstances, the presence of a chaperone provides protection for the osteopath, rather than presenting a risk for them. These circumstances include the examination and treatment of children and vulnerable adults, and examination and treatment of intimate areas.

129. In providing the guidance in the Code, the GOsC referred to the guidance given by other healthcare regulators and the CHRE. The guidance demonstrates that patients and practitioners should be able to choose when they wish to have a chaperone present. It emphasises that the presence of a chaperone is more important when examining and treating intimate areas and children.

130. The GMC's guidance on chaperones reads:

> 'Wherever possible, you should offer the patient the security of having an impartial observer (a 'chaperone') present during an intimate examination. This applies whether or not you are the same gender as the patient.
>
> 11. A chaperone does not have to be medically qualified but will ideally:
> - be sensitive, and respectful of the patient's dignity and confidentiality
> - be prepared to reassure the patient if they show signs of distress or discomfort
> - be familiar with the procedures involved in a routine intimate examination
> - be prepared to raise concerns about a doctor if misconduct occurs.
> -
>
> In some circumstances, a member of practice staff, or a relative or friend of the patient may be an acceptable chaperone.
>
> If either you or the patient does not wish the examination to proceed without a chaperone present , or if either of you is uncomfortable with the choice of chaperone, you may offer to delay the examination to a later date when a chaperone (or an alternative chaperone) will be available, if this is compatible with the patients best interests.

You should record any discussion about chaperones and its outcome. If a chaperone is present, you should record that fact and make a note of their identity. If the patient does not want a chaperone, you should record that the offer was made and declined.'

131. The GCC's Code of Practice contains the following standard and supporting guidance:

'Chaperones
You must identify when there is a need for another person to be present when you are assessing or caring for a patient, and make appropriate arrangements for this to happen.

Unless parental consent has been given for a child to be seen without someone else there or the child is competent to make his or her own decisions, then another person (who may be a parent) should always be present if the patient is a child. This might also be appropriate if the patient is a vulnerable adult. Patients might also ask to have someone to accompany them when they are being assessed or cared for.'

132. The CHRE provides guidance for patients and carers on *Clear sexual boundaries between healthcare professionals and patients*. This guidance contains the following advice in relation to chaperones:

'Having another person present
You or your healthcare professional may want to have another person present during an examination or procedure. This person is sometimes called a chaperone. A healthcare professional should always ask you if you would like someone present during any examination or treatment that you consider to be intimate. This can be someone of your choice or another healthcare worker with whom you feel comfortable.

Looking after yourself
The healthcare professional also has the right to have someone else present during an intimate examination. They will try and select someone who is acceptable to you. If you are not happy with the suggested person you can ask for the appointment to be rearranged so that an acceptable person can be found.

If a healthcare professional wants a third person to be present but you do not, you should discuss your feelings with the healthcare professional and ask them why it is necessary.'

133. In its guidance *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professions*, the CHRE advises:

> **'Good practice in maintaining healthcare professional/patient relationships**
> Regulatory bodies provide specific guidance on the standards of professional conduct that apply to relationships between healthcare professionals and patients/carers. This may include guidance on communication, consent, confidentiality, procedures for intimate examinations and use of chaperones. Good practice in these areas is an important part of the maintenance of clear sexual boundaries. This document does not seek to reproduce or replace regulators' own guidelines. However it is recommended that regulators ensure their existing guidelines and training materials, and those produced in the future, cover the points outlined in this section as relevant to their professional group.
>
> **Chaperones**
> Wherever possible patients should be offered the choice of having an impartial observer, or chaperone, present during an examination that the patient considers to be intimate. If a chaperone is present, the healthcare professional should record the fact and make a note of their identity and status.
>
> **Choosing a chaperone**
> A chaperone does not need to be a healthcare professional but ideally they should understand the procedures involved in the examination. They should be sensitive to the patient's dignity and privacy, be prepared to support the patient if they show signs of discomfort or distress and be confident to raise concerns about a healthcare professional should suspected misconduct arise.
>
> In some circumstances, a member of staff or a relative or friend of the patient may be an acceptable chaperone.
>
> **If no chaperone is available**
> Sometimes a chaperone is not available, or the healthcare professional or patient may not be comfortable with the choice of chaperone. Under these circumstances the healthcare professional should offer to postpone the examination until a date when an appropriate chaperone is available, if this is compatible with the patient's best health interests. The healthcare professional must ensure that a patient does not feel compromised or pressurised into proceeding with an examination if a chaperone, or an acceptable chaperone, is not available.

When a patient declines a chaperone

Patients may decline the offer of a chaperone for a number of reasons. They may think it unnecessary because they trust the healthcare professional, for example, or they may worry that they will be even more embarrassed with another person in the room.

The healthcare professional should record any discussion about chaperones and its outcome. If the patient does not want a chaperone, the fact that the offer was made and declined should be recorded.'

134. The inclusion of guidance on the provision of chaperones in the OPS is necessary. The CHRE guidance makes it clear to patients that they may choose to have chaperone present, if they wish. It highlights to patients that they should expect a chaperone to be offered or present when their examination or treatment involves an intimate area.

135. The guidance given by other regulators is mixed but does highlight the importance of chaperones when examining or treating intimate areas and children or vulnerable adults. The presence of a chaperone, particularly in these circumstances, provides protection for both the patient and the practitioner. GOsC fitness to practise cases highlight that there is a greater risk to the osteopath who does not have a chaperone present, than there is to the osteopath who allows a patient to bring along a relation or friend.

136. The guidance provided in the OPS should properly highlight the need for an osteopath to offer a chaperone if they are examining or treating intimate areas, treating a patient under 16 years of age or treating an adult who lacks capacity.

137. In the current guidance, it is also recommended that a chaperone should be offered when treating a patient in their home. This guidance, whilst not reflected in other regulators' codes of practice, is important. It is there to provide protection to the osteopath who may find themselves alone in a patient's house and potentially attending a patient who may be bedridden. The presence of a chaperone, whether it be the patient's family member or another chaperone, provides protection and reassurance for both the patient and practitioner.

Who has to provide the chaperone and who has to meet the cost?

138. If a patient requires a chaperone to be present and the osteopath is not comfortable allowing the patient to bring along a relative or friend, the osteopath may have to make provision for a chaperone to be present. Alternatively, the osteopath could refer the patient to another practitioner for treatment.

Sole practitioners

139. A sole practitioner is perhaps more vulnerable than a practitioner who works in a group practice and the use of chaperones can mitigate risks for the practitioner.

140. It was acknowledged that for a home visit it may be difficult for an osteopath to take someone with them as a chaperone if the patient could not provide their own. It was accepted that sole practitioners may struggle to provide a chaperone in these circumstances. However, it was possible to mitigate this difficulty as the requirement is to ask the patient if they would like a chaperone and not necessarily provide this. For home visits the question can be asked in advance and if the patient would like a chaperone, they could be asked to make suitable arrangements themselves, i.e. a relative, neighbour or friend. If they are unable to provide their own chaperone and the osteopath could not provide one, the appointment could be re-arranged for a date when a chaperone was available or the patient could be referred to another practitioner. The guidance should be clear that this only requires an osteopath to ask the patient whether they require a chaperone – the provision of a chaperone can be achieved through a number of different means.

Agreed action:

a. C6 guidance paragraph 11 should now read 'you should ask the patient if they would like a chaperone when:'.

b. The final sentence in C6 guidance paragraph 13 should be replaced with 'If a patient who falls into the categories at paragraph 11 declines the offer of a chaperone, you should record that too.'

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Other discussions

141. As well as the main issues discussed above, there were a number of other areas of discussion, suggested amendments and responses to questions which were considered by the GOsC. These are presented in the table below. Entries in the table are grouped under the following headings:

Section A – consideration of section A of the OPS document.

Section B – consideration of section B of the OPS document.
Section C – consideration of section C of the OPS document.
Section D – consideration of section D of the OPS document.
General – consideration of general comment on the OPS document.
Format – consideration of formatting issues related to the OPS document.
Additional – consideration of issues additional to the OPS document.
List of topics for consideration in terms of supplemental guidance.
Recommendations from Hewell Taylor Freed & Associates in relation to consultation methods employed by the GOsC.

Section A

Standard /guidance	Comment/proposed change	Discussion	Agreed action
A - Introduction	From the consultation analysis 'It was felt that the use of the term "absolute trust" in the introduction to Section A was not appropriate, and impossible to achieve. It was suggested that this (at best) could only be an aspiration or an ideal, although "ethical behaviour....should be an absolute demand on us as osteopaths". Another comment was "... how un-osteopathic this statement is - we work together - osteopathy is not paternalistic". Patients expected to be able to trust their osteopath and their decision making processes.'	On reflection the use of the term 'absolute' here creates an unfair expectation on the osteopath. Removing the term absolute would still maintain the meaning of this sentence. Adding 'mutual' or 'therapeutically earn trust gradually' would cause confusion to the reader. This is not considered paternalistic as the purpose of the document is to outline what is required of the osteopath. In this case stressing the importance of the therapeutic relationship whilst outlining the osteopath's role in establishing and maintaining this.	Remove the term 'absolute' and change the sentence to: 'The therapeutic relationship between osteopath and patient is built on trust and confidence. Osteopaths must communicate effectively with patients in order to establish and maintain an ethical relationship.'
A1	'A1 guidance 1.1; 1.2; 1.3 are too vague examples are needed'	This document is not intended to provide criteria for the assessment of the	Cross-reference to explanatory note in

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	'A1 Give example of what is meant Standard A1 guidance 1.1 & 1.2 - Need to define 'range & form' – must include verbal and non verbal' 'Standard A4 guidance 12 – This is fine if guidance 1.1 is more appropriately defined (see note above)' 'A1 – Communication strategies could be interpreted as needing to speak various languages (two focus groups)' 'A1 - 'Must have' …communication, this cannot be measured objectively change to 'should'.' 'Patients felt that assurance should be given when treatment was feeling uncomfortable and they expected to have confidence in their practitioner.' From the equality impact assessment: The emphasis on effective communication and appropriate forms of communication in A1 is positive, emphasising that osteopaths may use different forms of communication in response to their own circumstances or those of a patient (for example, someone who is deaf may	knowledge/skills required. The intention in this section is to outline the high-level skills required in order to practise. If further detail is required, this would need to be in an educational document such as the benchmark statement. The educational institutions will also map their courses against the standard and Code. This area will be further explored as part of the work conducted by GOsC on pre-curriculum review. The range and form of communication is explained in greater detail in the Code guidance and will be cross-referred.	Code section.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	prefer to communicate through using notes). The specific example is also helpfully given at A.3.10 of engaging a sign language interpreter.		
A2 guidance 3	'Communication - the guidance at A2 3 refers to a patient's unspoken signals, which may be seen to disadvantage a practitioner with visual impairment.'	It was **agreed** that the guidance should be changed to address this point. Osteopaths with visual impairments may rely on other senses to pick up on a patient's unease, such as a change in their tone of voice, and the guidance should include this example.	A2 guidance 3 amended to: 'You should be alert to patients' unspoken signals; for example, a patient's body language or the tone of their voice may indicate that they are nervous or experiencing discomfort.'
A2 guidance 5	A number of osteopaths asked exactly what was meant by A2 guidance point 5 and in particular how it could be achieved by sole practitioners, e.g.: 'A sole practitioner without a receptionist is likely to need to take calls – patients may read into this guidance that they should not do that...'	This section is about communicating effectively with patients. To do this, an osteopath will need to give the patient their full attention during consultations. Distractions, such as telephone calls, can disrupt the flow of communication and cause the osteopath to miss key information or signs. Whilst it may be more of a challenge for sole practitioners, they too need to give their patients the same attention and so need to develop strategies for dealing with interruptions, e.g. use an answer-phone, leaving a 5-10 minute gap between appointments to avoid having to leave the	Amend text to provide additional clarification.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
		current patient to answer the door for the next patient.	
A2 guidance 6 & 7 A4 guidance 16 & 17 C6 guidance 9	Intimate areas.	Issue was discussed by OPS Working Group and reported in Intimate Areas section above (pg 40)	Agreed action reported at Intimate Areas section above (pg 40)
A3 guidance 8.3 A4	Communication of risk and seeking consent.	Issue was discussed by OPS Working Group and reported in Consent section above (pg 13)	Agreed action reported in Consent section above (pg 13)
A4 guidance 19	'Shouldn't consent be given by another informed clinician?'	No, the position of who can make decisions on behalf of a person who lacks capacity is complex and different legislation applies in different UK countries. The guidance given highlights a common theme – the treatment must be in the patient's best interest. Supplementary guidance on consent will be able to explain the various position and options in more detail. The guidance in the OPS must be high-level and alert the osteopath to the complexities in this area.	Amend text to provide additional clarification. A reference to the supplementary guidance will be added to the document when it is in its final stages.
A4 guidance 21 - 24	A range of issues on consent for young people and children.	Issue was discussed by OPS Working Group and reported in Consent for Young People section above (pg 22)	Agreed action reported in Consent for Young People section above (pg 22).
A4 - additional	It was suggested that it would be helpful to have a template produced for recording consent, and further guidance on how to meet 'minimum standards' in	It is intended that supplementary guidance is produced on consent. It is a complex area and it is only possible, within the OPS, to provide high-level guidance. It is unlikely that this	To produce supplementary guidance.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	this area.	supplementary guidance will include a template for recording consent.	
A5 & A6	There was general agreement that the patient's own role in the therapeutic relationship should be emphasised more in standards A5 and A6, in terms of communicating their symptoms/concerns, development of mutual trust and in following the guidance offered by their osteopath.	The standards reflect the partnership that is needed between an osteopath and patient. The guidance is aimed at osteopaths and intended to help them understand what they can do to achieve the standards.	No change.
A5 guidance 25	A5 guidance 25 – 'Some patients 'don't want to know'. Therefore 'patient should be given opportunity to ask questions..' would be more appropriate.'	It is important for an osteopath to encourage a patient to take an active part in their care. This is emphasised in the 'partnership' reference made in the standard.	No change.
A5 guidance 26	'There is no such thing as 'best treatment'. Decision is taken in partnership with patient.' '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.'	The purpose of this guidance is to highlight that osteopathic treatment may not be the most suitable option for the patient. It may be that the patient needs referral or advice, rather than osteopathic treatment.	No change.
A6 guidance 27	'Needs to change to: Supporting patients in caring for themselves **may** include'. Osteopaths have expressed concern about encouraging referrals to GPs and some interpreted the wording as	This guidance is aimed at achieving a more rounded package of healthcare for the patient. A patient's GP should know what other care they are/have been receiving, in the same way an osteopath will wish to know this information. The relationship difficulties	No change.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	requiring the patient to inform their GP of every visit. Change to 'inform GP on completion of treatment' – does this need to be included as in Scotland, good relationships with GPs is still patchy and they tend to refer (our patients) to physio waiting list. Should encourage patients to inform GP of positive outcomes.	between osteopaths and GPs should not compromise the sharing of this information. Inserting the words 'may include' or 'where appropriate' will weaken the advice given here.	

Section B

Standard /guidance	Comment/proposed change	Discussion	Agreed action
B & C - introductions	From the consultation analysis: Use of the term 'ethical' in a theme introduction'. Two of the themes (A and D) have introductions that include the term 'ethical'. There is scope for adding 'ethical' into the introductions for both themes B and C since it is unethical to practice without the requisite knowledge and skills and attention to safety and quality.'	Agreed.	Additional wording to introduction to Section B to add 'on an ethical basis'. Addition of 'ethical' to introduction of Section C.
B & C - introductions	The introduction to theme C does refer to the patient. But it fails to do justice to the quality of the respect for patient dignity and to the care and compassion of the practitioner, which are well expressed within the actual standards and guidance.	Agreed that this could be emphasised.	Additional wording to be added on 'patient dignity'.
B - general	A range of issues were raised about the language used in this section.	Issue was discussed by the OPS Working Group and reported in Format and Language section above (pg 7).	Agreed action reported in Format and Language section above (pg 7).
B1	A small number of osteopaths commented on the lack of emphasis on osteopathic principles and practice, and the distinctiveness of osteopathy, compared with other manual therapies.	This document is not intended as a scope of practice which delineates osteopathy from other healthcare. It is a set of standards for practice to be applied by osteopaths in the context of osteopathy. Whilst osteopathic principles are necessary, the standard does not need to go into detail about what these are. It simply requires the osteopath to have gained	No change.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
		these from prior training.	
B1 guidance 1.4	Standard B1 guidance 1.4 states that: '1.4. a critical appreciation of the highly skilled sense of touch, known as palpation.' Feedback on this in the consultation report was as follows: 'Many more who commented on this standard expressed concern about the wording of the guidance, particularly in relation to palpation (B1.1.4), which they felt was under-emphasised as a key feature *("the hallmark")* of the osteopath's range of skills, and how palpatory skills continue to develop, with experience, throughout the practitioner's life. Alternative suggestions were offered, including a comment that the old standard K1 expressed it much better, and another that 'the critical appreciation should be of the value and limitations of palpation rather than its definition'. However, a small number thought that palpation should be so well understood by osteopaths that it was not necessary to include it in this way'. Some more detailed feedback from osteopaths was as follows:	Capability K of the existing *Standard of Proficiency – Standard 2000* was removed and incorporated into other standards about patient evaluation and treatment. It was felt that, while this is an important area, it is just one aspect of an overall integrated evaluation of patients and should be incorporated into other relevant areas to highlight this integration.	It was agreed that the statement on palpation in standard B1 guidance 1.4 remains but is changed to: 'a highly skilled sense of touch, known as palpation.'

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	Section B1 (1.4) requires 'a critical appreciation of the highly skilled sense of touch, known as palpation.' The wording of this definition is somewhat confused. A person may be highly skilled in the use of palpation but palpation may not be described as highly skilled because only a person may have skill; the sense of touch cannot. In any case, it is unnecessary to define palpation here. The old standard, K1, made more sense and what is intended by 'a critical appreciation' might also be made clearer by extending this to include the limitations of palpation, giving instead 'a critical appreciation of the value and limitations of therapeutic touch and palpation'. The wording here is confused. Palpation cannot be described as a 'highly skilled sense of touch' because only a person can be skilled and palpation is ability not a person. Similarly, one cannot have a critical appreciation of a skill, only of its value. This should read: 'a critical appreciation of the value and limitations of therapeutic touch and palpation.'		
B2 guidance 2.1	Standard B2, guidance 2.1 states that: 'a detailed knowledge of human structure	It is recommended that the alternative wording for this section is clearer and more concise and	To use the wording suggested for B2

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	and function to be able to differentiate between normal and abnormal anatomical structures and processes, and develop treatment and rehabilitative strategies.' It was suggested that 'this wording is also somewhat confusing and rather vague. Try instead: 'knowledge of human structure and function sufficient to recognise and interpret clinical signs of dysfunction and develop appropriate treatment and rehabilitation strategies'.'	that this should be adopted.	guidance 2.1.
B2 guidance 2.3	Standard B2 guidance 2.3 states that: 'knowledge of human disease sufficient to inform clinical judgment and to enable recognition of disorders not suitable for osteopathic treatment.' The consultation report shows that: 'The majority of comments on B2 referred to guidance 2.3, knowledge of human disease sufficient to inform clinical judgement and to enable recognition of disorders not suitable for osteopathic treatment. We were told that osteopaths 'treat patients, not conditions', and most of these respondents stated that there were no patients whose symptoms/condition could not be eased by osteopathic treatment. '..... fails to	There are strong feelings from osteopaths on this section of the guidance and this mainly focuses on the way that this guidance is worded. In order to adequately reflect that osteopathy can act to treat symptoms of a wide range of conditions as well as act as a cure, it is recommended that the wording of this guidance is changed as follows: 'knowledge of human disease sufficient to inform clinical judgement and to identify where patients may require additional or alternative treatment from another healthcare professional.'	That the wording of B2 guidance 2.3 is amended to: 'knowledge of human disease sufficient to inform clinical judgement and to identify where patients may require additional or alternative treatment from another healthcare professional.'

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	recognise that osteopathy in its breadth is able to treat anybody regardless of their condition. The emphasis implied here is on the condition rather than treating the person - this misses one of the key aspects of being an osteopath'. Others added that as expressed, this guidance might limit the scope and development of osteopathy, as it could be interpreted as meaning that certain conditions exist that must not be treated.' Specific quotes from osteopaths include the following: 'There are no 'disorders not suitable for osteopathic treatment' as osteopathy involves promoting the physiological mechanisms underlying the body's intrinsic capacity for self-healing and self regulation and removing any physical obstruction that may impair them. Though there may be circumstances in which certain techniques or approaches may be contraindicated (covered in C2, 2.4) and situations in which treatment other than osteopathy is clearly necessary (covered in C2, 2.8 & C7 14.5), this never precludes the possibility of applying this principle of osteopathy with benefit. This is evidenced by the work of the Foundation for Paediatric Osteopathy in the NICUs at Barnet, North Middlesex and		

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	Chase Farm hospitals, the BSO's work with HIV patients and the palliative work that many osteopaths do with terminal cancer patients. It is also demonstrated in research showing reduced post-surgical discharge times for patients given osteopathic treatment in hospital after heart surgery. Everything after 'clinical judgement' should be scrapped.' 'There is no disorder (strictly, no patient?) that is not suitable for osteopathic care: treatment of 'compromised health in the patient' to make life better. Suggest removal of this statement.'		
B2 guidance 2.5	Standard B2 guidance 2.5 states that: 'an understanding of the principles of biomechanics to assess the appropriateness of effective use of force when applying osteopathic techniques.' From the consultation report, it was suggested that 'more clarity was needed in describing the degree of force (or 'level of pressure', as an alternative)'. Specific quotes include: a. '.... should require understanding of the principles of biomechanics as a	It was agreed that the existing guidance is clumsily worded and could be made clearer.	That the wording should be amended to: 'an understanding of the principles of biomechanics sufficient to apply osteopathic techniques safely and effectively.'

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	whole, not just the effectiveness of the use of force'. b. 'The old capability (A4) was somewhat clearer but the meaning has been lost in the editing and the resulting language is quite confused. Try: 'an understanding of the principles of biomechanics sufficient to apply osteopathic techniques safely and effectively [and judge appropriate levels of force].' The last bit [in brackets] is probably unnecessary.' c. 'B2 (2.5) requires 'an understanding of the principles of biomechanics to assess the appropriateness of effective use of force when applying osteopathic techniques.' The idea is fine but this is quite poorly worded and hence unclear. All techniques involve some force and low levels of force are nearly always appropriate, such as the force involved in light effleurage or indirect techniques, for example. The question is how much force is appropriate in this area for this patient at this time.'		
B2 guidance 2.10 & B4	Standard B2 guidance 2.10 states: 'the ability to critically appraise osteopathic	The OPS Working Group should note that both of these statements are contained in the	The wording of B2, 2.10 to be changed

Standard /guidance	Comment/proposed change	Discussion	Agreed action
guidance 5.2	practice.' Standard B4 guidance 5.2 states: 'monitoring the quality of the osteopathic care you deliver and acting on the findings. Some members of some of the focus groups seemed to interpret standard B4 guidance 5.2 as being about 'audit' and if this was correct they really wanted this clarified and many considered that B2 guidance 2.10 was actually 'self reflection'. The following comments illustrate this: a. 'This is rather vague and unclear. If it refers to clinical audit, this needs to be made much clearer. However, a great deal more discussion and debate needs to take place before such a requirement becomes mandatory for osteopaths. This is likely to be extremely unwelcome as the administrative and financial burden could be crippling for sole practitioners and those in part time practice. Not to mention the fact that there is no evidence that such a requirement would have any positive impact on the quality of care	guidance sections, rather than the standards section, so this does not make it compulsory to undertake clinical audit. In effect, both statements refer to both reflective practice and clinical audit, the latter being one way in which to achieve the former. The Working Group has a choice of making these statements more explicit to state that the way you 'critically appraise' or 'monitor your practice' is through self-reflection and/or clinic audit. There is a benefit from being explicit, but it would mean that a new benchmark was set where normal practice would involve self-reflection and clinic audit. Whilst the former is currently supported and encouraged through the CPD scheme, the latter is in its early stages of development for osteopathy and would require a lot of support to introduce. As part of the piloting for revalidation, clinical tools including audit tools have been developed for use and evaluation. In addition clinical audit tools have been developed by NCOR to support the profession. At this stage it is recommended that the wording of these sections is consistent, but that they do not specifically impose clinic audit until there is sufficient support for the profession. Some minor amendments to the wording are recommended.	to: 'the ability to critically appraise osteopathic practice. For example, this could be achieved through: ▪ self-reflection. ▪ feedback from patients. ▪ feedback from colleagues. ▪ case analysis or clinical audit.' The wording of B4, 5.2 to be changed to: 'You should keep your professional knowledge and skills up to date by: ▪ committing to continuing professional development (CPD). ▪ monitoring the

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	provided by osteopaths. In fact, there is a significant risk that the onerous bureaucracy involved would detract from patient care. This should not be introduced without a full independently conducted impact assessment and a profession-wide discussion and debate. In the meantime, a requirement for reflective practice, which is a well-established mechanism for maintaining high standards, would be more than sufficient. For example: 'evaluating the quality of the osteopathic care you provide and planning your CPD activities accordingly'.' b. 'B4 guidance 5.2 - If this is about auditing we must be given an 'audit system tool' by GOsC...' c. 'B4 guidance 5.2 - Is monitoring a core function of osteopaths? It is impractical for small practitioners, and can make an imposition on the patient. The reflective practitioner model is a better way to ensure that quality is maintained. Imposing unrealistic bureaucratic forms of monitoring could undermine the viability of osteopathic businesses'.		quality of the osteopathic care you deliver and acting on the findings. This could be achieved through: ▪ self-reflection ▪ feedback from patients. ▪ feedback from colleagues. ▪ case analysis or clinical audit. ▪ keeping up to date with contemporary advice related to osteopathic healthcare and integrating this into your clinical practice.'

Standard /guidance	Comment/proposed change	Discussion	Agreed action
B3	Standard B3 and related guidance states: 'Recognise and work within the limits of your training and competence. 2. You should use your professional judgement to assess whether you have the training, skills and competence to treat a patient. If not, you should consider: 3.1. seeking advice or assistance from an appropriate source to support your care for the patient. 3.2. working with other osteopaths and healthcare professionals to secure the most appropriate care for your patient. 3.3. referring the patient to another appropriate healthcare professional, where you reasonably believe that that professional is competent. 4. You also need to identify and work within your competence in the fields of education and research'. The consultation report shows a number of	It is suggested that osteopaths, like other healthcare professionals should not be treating patients by any means which fall outside of their level of skill and competence. To do so would endanger patients. An argument has been put forward that this would restrict what osteopaths could do. This argument is rejected on the grounds that osteopaths can expand their levels of knowledge and competence through further training/continuing professional development and/or research where this has been granted ethics approval. Osteopaths should not, however, be experimenting randomly on patients in order to expand their knowledge.	That the existing wording of B3 remains the same, but with an additional guidance note added which states that: 'osteopaths will be able to expand their training and competence as outlined in standard B4 or through research'. Standard B4 states: 'Keep your professional knowledge and skills up to date.'

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	strong views on this section from osteopaths who do not believe that this condition is appropriate or feasible: a. 'Both experienced and recently-qualified respondents felt that B3 needed further consideration. Whilst the sense of it was broadly understood, the majority felt that it would be impossible for practitioners and practice to develop if the standard was followed to the letter. b. 'The meaning behind B3 guidance 4 in particular was questioned. The following comment usefully covers this point: '..the real issues here are that treatment must be safe and that practitioners must recognise when a patient needs treatment that is beyond their skill and ability to deliver. However, in many cases, the latter is only determined through a trial of treatment conducted with the patient's informed consent'.' c. 'It was clear from discussions at the focus groups that there was a considerable amount of confusion as to what standard B3 and its related guidance, particularly guidance 4, actually meant. The following comment was typical:		

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	'B3 - This appears to stop an osteopath developing. It was questioned whether this should say 'If working in area of research...' and also if it actually meant the osteopath should work in research /education. 'What does it actually mean? Currently it is too open to interpretation...'. d. 'This standard needs a complete rethinking. Though the idea of working 'within the limits of one's training and competence' seems sensible on the face of it, this does not allow for learning and development, which always involves working at or beyond those limits in the beginning. Practitioners must be free to take on patients whose problems are beyond their experience otherwise trainees and new graduates would never be able to get started. Similarly, they must be free to try new techniques to allow for continuing professional development and innovation.' e. 'The real issues here are that treatment must be safe (covered elsewhere) and that practitioners must recognise when a patient needs treatment that is beyond their skill and ability to deliver. However, in many cases, the latter is only		

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	determined though a trial of treatment conducted with the patient's informed consent.' f. 'The notions of 'limits' and 'competence' are too black and white given these considerations. The standard should focus instead on the need for a critical appreciation of one's skills and abilities in determining the most appropriate course of action. In addition, 'training' should be replaced with 'knowledge' to reflect the fact that personal study and clinical experience are equally valid forms of learning as formal training. This would give something along the lines of 'Clinical decisions should be based on a critical appreciation of your knowledge, skills and abilities'.' g. In addition, it is often uncertain whether one's knowledge and skills are adequate to the patient's care. 'If not' should therefore be changed to 'if this is in question'. This would give 'You should use your professional judgement to assess whether you have the knowledge, skills and abilities to safely and effectively treat your patients. If this is in question, you may consider...'. However, a different view is shown in the		

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	response from a patient group: 'Working within your competence (B3): this is an issue which is critical to patient safety and B4 also prompted a number of requests for clarification, for example: 'In other professions, reflective practice is the norm, and many osteopaths use it as a means of professional development, yet it is not mentioned here as a requirement'.		
B4 guidance 5.3	Standard B4 guidance 5.3 states: 'keeping up to date with contemporary advice related to osteopathic healthcare and integrate this into your clinical practice.' The consultation report tells us that: 'Almost all respondents asked for clarification or better wording on guidance 5.3: some wanted to know about relevant/acceptable sources of contemporary advice, with others advocating a role for the GOsC in signposting practitioners to this. Most suggested that at the least, the words 'as appropriate should be inserted in this guidance.'	It is important that osteopaths are making use of relevant and contemporary advice related to osteopathic healthcare. This is a responsibility of all healthcare practitioners including osteopaths. The GOsC is not responsible for the collation and signposting of contemporary advice in the same way as an organisation such as the NHS or NICE. The GOsC does, however, offer resources through its website, including weblinks to useful sites and may from time to time produce supplementary guidance for relevant areas of practice. The onus however will be on the osteopath to keep up-to-date.	No change.
B4 addition	An additional, but significant suggestion was provided by a patients' group: 'Sole practitioners (B4): as with other	Whilst this statement is relevant to the context of osteopathy as it currently stands (with approx. 90% of osteopaths in sole practice),	That the standards listed in OPS will remain the same.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	healthcare professions, there are inherent risks attached to sole practitioner status in terms of a lack of day-to-day professional support and peer review by work colleagues. We would recommend that the standards and guidance are amended to take account of the particular issues that arise in sole practice and to safeguard against the type of problems that can arise when a professional is working in relative isolation'.	the standards must apply to osteopaths in all situations. Where the GOsC feels it necessary to provide further information for sole practitioners within the text of the guidance it should do so, but this may be better dealt with through supplementary guidance.	That the guidance will be reviewed to ensure that where references to sole practice are required, these will be included. That any detailed advice would need to be considered as supplementary guidance.
Additions to section B	From OEIs: 'No-one speaks about 'observation' as a skill/technique (in this document) in the way that palpation is described as a skill, but observation is key, and is taught'.	Standard B2 guidance 2.7 refers to the need to observe in connection with determining changes in tissue and joint movement.	No change.
Additions to section B	'Appropriate referral – GPs have often referred the patient to the osteopath, so it is sometimes difficult to know who to refer a patient to. This needs to be recognised and made explicit in the document'.	The guidance provided gives options to an osteopath who has recognised that they may not be competent to treat a patient. Referring them to another healthcare profession is a viable option and so this advice should remain.	No change.

Section C

Standard /guidance	Comment/proposed change	Discussion	Agreed action
C1	Use and application of the word 'diagnosis' in the osteopathic context, and on the subsequent treatment plan required.	Issue was discussed by OPS Working Group and reported in the section Use of the Word 'Diagnosis' above (pg 24).	Agreed action reported in the section Use of the Word 'Diagnosis' above (pg 24).
C1 guidance 1.3	'C1 guidance1.3 - Training of osteopaths doesn't fully cover all the factors listed. The word 'recognise' should be replaced by 'be aware of '.'	The current training of osteopaths is mapped to both the *Standard of Proficiency* and the *Code of Practice*. Those that were not trained in certain areas of these documents are expected to make up the shortfall through CPD.	No change.
C2	Treatment plans – do these need to be written? The nature of patients' responses to treatment should be reflected in the guidance on treatment plans – the phrase 'treatment plan' should be changed to 'objectives' or 'management plan', in order to acknowledge that sometimes treatment is not required. A small number of practitioners commented that in C2, the guidance gave the impression that osteopathic treatment was a set of 'justifiable' procedures and techniques, and excluded the need for	The treatment plan should be recorded in the patient's records (see C8, guidance 16.7). There is no requirement to produce a written treatment plan for the patient to take away. If a patient requests a written plan, it would, however, seem reasonable for the osteopath to provide it in this form. Changing the term 'treatment plan' is rejected as this would become less clear to external audiences what is meant. Whilst the initial treatment plan is devised in 2.3, sections 2.5-2.8 appreciate the need to update and amend treatment plans post-treatment and on re-evaluation, especially	No change.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	overall evaluation of the patient, 'i.e. their predisposing or maintaining factors, health beliefs, psychological status etc.', all of which would have a bearing on finding the best course of action for them. Patients expected the osteopath to have a plan of action with regards to treatment and management.	after adverse events. The factors mentioned here are referred to in section C1.	
C2 addition	Patient group: 'C2: in addition to guidance note 2.8, we would suggest additional guidance on recognising when errors have been made and best practice on how to respond to the needs of the patient'.	Agreed.	Changes made to text.
C3	'…requirement to understand the patient's condition seemed unworkable, and should perhaps include 'do your best' to understand…'	Agreed.	Changes made to the text.
C5/D4	'...need to ensure that treatment is not directed by patient and this guidance should not be interpreted as ...the patient being allowed to say (e.g. 'just crack my neck'), which may be a completely inappropriate treatment'. From the equality impact assessment (EIA) report: 'C.5.6. makes explicit the tension between accommodating patients' wishes and not	Osteopaths should never deliver inappropriate treatment to their patients whatever the circumstances. This is not the purpose of the standard. Comment from EIA report is discussed further under D4.	Changes made to text at D4 (see below). Consider 'modesty of dress and restrictions to treatment' as topic for supplementary guidance.

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	compromising the care provided. A key issue, which is clear in the consultation responses, is that of modesty of dress and restrictions to treatment, particularly where these are prompted by religious belief (Hewell et al, page 20, 21). Further guidance on this topic might be useful.'		
C6 guidance 7 & 8	The issues relating to modesty were debated long and hard amongst the profession with a very wide range of views and opinions.	Issue was discussed by OPS Working Group and reported in the section on Modesty above (pg 36).	Agreed action reported in the section on Modesty above (pg 36).
C6 guidance 11	The provision of chaperones and interpreters led to considerable debate amongst the profession and variance of interpretation.	Issue was discussed by OPS Working Group and reported in the section on Chaperones above (pg 44).	Agreed action reported in the section on Chaperones above (pg 44).
C7 guidance 14.4	Almost all of those who commented on C7 raised concern about guidance 14.4 - a similar point was made about B3, regarding working within the limits of their competence. For example: 'Whenever we learn a new technique or approach and set out to integrate this into our clinical practice, or when we are developing new techniques and approaches, we are at the edge of our competence, if not beyond it. This standard needs to reflect this ongoing process of development'.	The guidance at 14.4 suggests referring a patient elsewhere when they need treatment that the osteopath cannot provide. This is sensible advice and should remain. A separate issue is whether an osteopath should be treating patients beyond their competence in order to develop their skills. If an osteopath is developing a new skill or technique on a patient, that patient should be properly informed and allowed to give or withhold their consent.	No change.
C8 guidance	OEI: 'Standard C8 – guidance 16 –	Agreed.	'..., which includes

Standard /guidance	Comment/proposed change	Discussion	Agreed action
16	Recording findings – should mention negative findings as well as positive findings'.		negative findings' added to end of guidance 16.5.
C8 guidance 19	'Some respondents expressed surprise at the length of time that they were expected to retain patient records, and wondered if this was a legal requirement. Others also commented on the arrangements for safe-keeping of patient records after the death of the practitioner; this could cause logistical and legal problems, and perhaps it should be for the GOsC to store them.'	The guidance provided on the length of time that osteopathic records should be maintained reflects the guidance given by the Department of Health for medical records. Osteopaths need to ensure that they have provisions in place to deal with all aspects of their practice, in the event of their death.	No change, but the basis for length of time that records should be maintained should be emphasised in communications.
C9	'Feedback received on standard C9 was almost unanimous in saying it was not possible to keep patients from harm **whatever** the cause.'	Removing 'whatever the cause' from the end of the sentence would retain the meaning whilst removing any unrealistic expectation that osteopaths will be able to maintain patient safety no matter what circumstance or situation arises.	Remove 'whatever the cause' from the text, as this is explained in the guidance note.
C9, guidance 21 and 22	Consultation report: C9, guidance 21 and 22, is a valuable addition and an ethically important one to address. There is no direct reference to the ethically difficult situation where staff may need to raise concerns about the principal of a practice. 'C9 guidance 21: Acting quickly is not always safe: sometimes you need time to reflect. Suggest adding a further point to acknowledge that the best action is sometimes to gather more information.'	A range of options for discussing concerns or reporting them is suggested in the report at paragraph 21. The term 'act quickly' in the standard is designed to demonstrate that taking protective steps must be a priority.	No change.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
C9, guidance 23	Students have expressed a requirement for greater clarity and emphasis on the necessity for the osteopath to remain updated and clear regarding the referral pathways for safeguarding children and vulnerable adults.	The options available for raising concerns or referring children or vulnerable adults for support/care are wide ranging and could not properly be covered in the OPS. This is an area that should be considered for supplementary guidance.	No change to the OPS but consider for supplementary guidance.
C - additions	A small number of respondents commented on the lack of reference in section C to cleanliness, standards of hygiene and use of protective clothing/gloves, where appropriate. Others asked specifically for guidance on standards required in the case of a pandemic, where clinic staff could be at risk.	Clinical hygiene advice could be quite detailed and is probably best not dealt with in this document. It may also need to be updated regularly as things change.	Suggest that clinical hygiene is dealt with in supplementary guidance.
C - additions	In the various standards and guidance relating to patient records, a surprising omission is the lack of an explicit ethical statement that patients should have the opportunity to see and access all records relating to their care. The active involvement of the patient in the treatment plan (A5) and the need to take account of their wishes (C2, guidance 2.3) could be enhanced by 'showing' or 'sharing' the actual treatment plan with the patient.	Agreed that this should be included within the OPS.	Due to changes between C8 and D6 , a new paragraph will be inserted in D6 as follows: 'Patients are able to see their notes and you should assist them with this if such a request is made.'

Section D

Standard /guidance	Comment/proposed change	Discussion	Agreed action
D1	Respondents sought clarification in D1 1 1.-1.3, and the meaning of 'operational relationships' in 1.4. 'D1 1.5 should read 'appropriate and available' (rather than and/or).'	Important to provide clarity.	Wording changes made in 1.1 – 1.3 to improve clarity. Operational relationships removed from 1.4. Change to 1.5 accepted.
D2/D3	Concerns were expressed about the likely expense for practitioners to introduce IT systems, and a potential lack of standardisation in this – the GOsC should lead on advice and support for practitioners to meet these standards. Although some respondents felt that IT was being imposed upon them, in spite of their maintaining efficient paper records, others remarked that in line with other professions, osteopathy is fast approaching the time when IT systems will be an essential/integral feature of their practice. From the Equality Impact Assessment report: D2.2.2, D3 and B.4.5.2 could be taken to imply that all records should be kept electronically, which could be seen as prejudicial against those who, for disability	This condition has been worded so that as long as you meet the standards the way it is achieved is irrelevant. Hence the use of 'a sufficient knowledge of IT…'. As IT becomes more prevalent in healthcare, osteopaths will need to keep pace in order to interact with other healthcare practitioners appropriately. Whilst supplementary guidance may be considered on how to collect and analyse data (i.e. clinical auditing tools produced by NCOR and GOsC revalidation clinical tools), the GOsC would not be advising on IT packages for professionals. Computer use – it was suggested that D2.2.2, D3 and B.4.5.2 could be taken as implying that all records should be kept electronically, which	No change.

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	or other reasons, are reluctant or unable to spend long periods of time working on a computer. It may also affect those who do not have administrative support, for example those not in group practice and those who practise part-time.	may discriminate against certain individuals. It was recognised by the Working Group that although many osteopathic practices may wish to move towards paperless practices, this was not the reality at the moment. Reflecting on the wording of the relevant standards, it was agreed that they did not require records to be kept in an electronic form and it was not necessary for the standards to be redrafted.	
D2/D3	Many people commented that standard D2/D3 and guidance 2.4 (particularly) seemed to relate to audit. For some this seemed to cause concern, while others simply asked that if this is what is meant, it should be clearly stated and detailed requirements need to be provided, after further discussion across the profession. It was noted that this might even belong as a standard in section C, as a quality issue.	Osteopaths should be able to evaluate the data they store. The intention of guidance 2.4 is for an osteopath to be able to collect and analyse data which may be required for other purposes. One of these may be to monitor the quality of practice, but this is not a requirement of the GOsC.	To remove the wording 'to monitor the quality of your professional practice' from the end of the sentence at D2/D3, 2.4.
D4/C5	From consultation report: 'Whether or not to include conscience clauses within practice standards is often debated. But it may be appropriate for D4 and/or D5 to be balanced by such a clause, i.e. that if personal, religious or moral/ethical beliefs prevent a practitioner from providing a particular service, then the professional body should be made aware of	Refusal of provision of treatment because of religious or moral/ethical belief. All patients are entitled to receive osteopathic treatment. It is illegal to refuse a service to someone on the grounds of their gender, ethnicity, disability, religion or belief, sexual orientation, transgender status, age or marital	To replace paragraph 2 of standard D4 with: 'If carrying out a particular procedure or giving advice about it conflicts with your personal,

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	this and affected patients given a polite explanation and referred to another practitioner.' [Please also refer to comments under C5]	status. It is recognised that there are some procedures that an osteopath may perform or advice that they might give which conflicts with their own personal religious or moral/ethical beliefs. In these circumstances, the OPS document must be clear on the approach which the osteopath should take to deal with this while still ensuring patient safety and complying with the law. It is suggested that where an osteopath encounters these conflicts, they must clearly explain to the patient what the conflict is and offer them the option of seeing another osteopath. A good example of where this is clearly explained is the GMC publication, *Good Medical Practise (2007)*. It is proposed to use a version of this wording in the guidance at D4.	religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell them they have the right to see or be referred to another osteopath.'
D4	'Should D4 and D5 be combined?'	No, D4 is focussed on the practitioner's own believes and values and the need to ensure that these do not prejudice their patient's care. D5 highlights the need to comply with equality and anti-discrimination law, such as the Equality Act 2010.	Additional guidance has been added to the document to support D5.
D4, guidance 3	'Reference to the views of the registrant might not be the most helpful way of	It was agreed that the guidance provided at D.4.3 was an important statement of principle:	Changes made to text.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	achieving the intention of this guidance. An alternative wording might be – the same quality of service should be provided to all patients regardless of their gender, ethnicity, disability… From the Equality Impact Assessment report: D4.3. is an important statement of principle: that osteopaths should guard against prejudices based on a patient's gender, ethnicity, disability, culture, religion or belief, sexuality, lifestyle, age, social status or language.	that osteopaths should guard against prejudices based on a patient's gender, ethnicity, disability, culture, religion or belief, sexuality, lifestyle, age, social status or language. This guidance would remain unchanged.	The report recommended that the term 'sexual orientation' be used in place of 'sexuality' (replicated throughout document).
D5	Most respondents felt that D5 should include exhaustive information on reasons for declining to continue treating certain patients (5.3), or state more emphatically that the list is not exhaustive. Others felt that the examples did not fit well with the standard, and some illustrations of what constitutes discrimination would help in meeting the requirements of both D4 and D5. OEIs: 'Section D5. The examples in paragraph 5 of the guidance are too extreme and could be taken in the wrong manner by patients. These examples and	The guidance at paragraph 5 relates to standard D4. It is not possible to include an exhaustive list of the reasons why a practitioner may terminate their contract with a patient. Osteopaths need to apply their professional judgement. Whilst the list provided may seem extreme to some osteopaths, others have sought advice from the GOsC on how to manage abusive or aggressive patients and what to do when a patient becomes inappropriately dependent on them, e.g. begins to stalk the osteopath.	No change in terms of an exhaustive list. Guidance at D5 to include a statement to the effect that it is illegal to refuse a service to someone on the grounds of their age, disability, gender, ethnicity, marital status, sexual orientation, religion or belief, transgender status.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	this guidance do not fit well with the standard. There are no examples of what does constitute discrimination and some examples here would be useful.' From the Equality Impact Assessment report: 'D.5.5. It may be helpful to clarify that it is illegal to refuse a service to someone on grounds of their age, disability, gender, ethnicity, marital status, sexual orientation, religion or belief, transgender status.'	These examples are, therefore, relevant. The guidance highlights the need to try to make relationships work with patients but recognises that, in some more extreme situations, this will not be possible.	
D6	D6 6.6 and later: The definition of 'valid' consent again caused comment, as in section A - is consent only valid if obtained in writing? D6, guidance 8 and 9, concerns disclosure with and without consent. There are distinctions between legal requirements to disclose and legal permission to disclose, which have ethical implications for patients. Whether or not patient consent is required, it may still be ethically appropriate to inform the patient about such actual or planned disclosure unless specifically prohibited (e.g. in a criminal investigation) or advisory (e.g. where a patient may become violent). And, whether disclosure is legally required or permitted, ethically disclosure should be	We have assumed this relates to point D6, guidance 8 and 9 – this relates to receiving consent to disclose information. If the osteopath follows the guidance given in paragraphs 8.1 and 8.2, this will make any consent given 'valid'. Paragraph 8.3 does advise that the patient should be asked to give their consent in a written form. Additional guidance should be provided to advise that, if an osteopath intends to disclose information without the patient's consent, they should inform the patient of this intention, unless there is good reason not to.	The following paragraph to be inserted under D6 guidance: 'If you need to disclose information without your patient's consent, you should inform the patient, unless you are specifically prohibited from doing so (for example, in a criminal investigation) or there is another good reason not to (for example, where a

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	proportionate and limited to the relevant details. Information disclosure/sharing agreements exist between bodies such as the NHS, police, and Social Services within local authorities.		patient may become violent).'
D6, Guidance 6	'Also some repetition/overlap here on confidentiality and security of information (6.2 and 6.5). The GMC website was quoted as an excellent example of an online tool that could be adapted: www.gmc-uk.org/gmpinaction'	It was discussed whether there was a clear split between D6, 6 and C8 in terms of information. It was agreed that wording should be made clearer in order to separate requirements on the content of information from requirements on security and confidentiality.	Changes made to wording so that C8 focuses on requirements for the content of records, whereas D6 focuses on requirements for security and confidentiality.
D6	*'D6 - should this specify a time period for keeping confidential information?'*	Guidance is provided at C8, paragraphs 19 and 20.	No change
D7 (and A2)	From patient feedback: 'it was recommended that these sections should include as one of the core standards a reference to openness and honesty in dealing with patients and colleagues, with particular reference to dealing with adverse outcomes and complaints. Quote: "A complaints procedure will work effectively, if the underlying ethos is one of openness and honesty. The foundation of 'trust' which is referred to within the document is openness and honesty and so this should be recognised as a fundamental attribute of a healthcare professional".'	Agreed that this should be included for the reasons given, but it does not fit well in A2.	Amended standard D7 to include at the beginning: 'be open and honest when dealing with patients and colleagues and respond quickly to complaints.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
D7 guidance	'D7 guidance would be strengthened by respecting the need for patient information through the provision of visible leaflets/posters within each practice explaining procedures and contacts for complaints. It is helpful to balance this by encouraging 'compliments and comments' rather than just complaints. Most comments on D7 suggested that guidance 12 and 13 should be reworded to lay more emphasis and advice on trying to resolve the complaint locally, before allowing the issue to be escalated to GOsC'	Agreed	Changes made to the text of guidance at D7 to include paragraph: 'You may wish to provide information to patients about how they can make comments, including compliments, about the service they have received.'
D7 guidance 13	'It was noted that not all practitioners belong to a professional association, and this should be reflected in guidance 13'	Advising osteopaths to inform their professional association when they receive a complaint is very important. Whilst not all osteopaths are members of a professional association, those that are should be advised to take this step.	No change.
D7 guidance 12 & 13	'Most comments on D7 suggested that guidance 12 and 13 should be reworded to lay more emphasis and advice on trying to resolve the complaint locally, before allowing the issue to be escalated to GOsC.'	Agreed that the emphasis should be on trying to resolve complaints locally but GOsC option still needs to be available.	Rearrange paragraphs 12-14 to produce different emphasis.
D8 guidance 17	'Most respondents who commented on D8 questioned the rationale for the guidance on associates (D8 17), who are normally fully qualified, insured and self-employed, and as	This guidance does not suggest 'supervising' an associate. An associate may be able to stand alone as a fully qualified and insured practitioners but some associates will be newly	No change

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	such their osteopathy would not be supervised.'	qualified and may need more time with patients than a more experienced practitioner – for example to elicit the case history. Some associates can find themselves under pressure to, for example, bring in a certain amount of income. Others feel that they are not being given the time they need to complete their notes to the standard they wish to maintain. A principal of a practice has responsibilities for their associates and should be alert to this.	
D8 guidance 21.1	'We were surprised to read that students in an osteopathic practice (other than a college clinic) might carry out osteopathic examination, treatment or advice. Please can the GOSC detail what it permits as we were of the opinion such an action was not allowed.'	This might cause confusion over what is allowed. We need to be clear that osteopathic students in private clinical placements need to be under the direction of a course provider.	Amendments to text at 21.1 to clarify position that student placements for examination and treatment must be part of an agreement with a GOsC-recognised OEI.
D10-D13	In D10-D13, guidance 25, clarification was sought on how to define "appropriate" and "adequate". Some respondents thought this guidance might fit better in Section C (Safety and Quality in Practice), with more specific advice on health and safety requirements.	Standards D10 to D 13 should be moved to section C. Links to other sources of advice, such as the guidance provided by the Department of Health on communicable diseases can be included in the document.	Standards D10 to D13 and its supporting guidance should be moved to appear between C8 and C9.
D10	From the Equality Impact Assessment: 'D.10.25. is an important statement relating to avoiding transmission of communicable	It was agreed that this should be included in supplementary guidance on the wider subject healthcare practitioners working with	To be explored as part of supplemental guidance

Standard /guidance	Comment/proposed change	Discussion	Agreed action
	disease. It may be helpful to have specific guidance available on HIV, which is extremely unlikely to pose any risk as long as very basic precautions are taken. This would ensure that existing practitioners, students and those considering the profession are not discouraged from practising.'	communicable diseases.	
D11/D14	'There was also thought to be some overlap between D11 and D14 guidance 27 *'D11 - communicable diseases: some felt more definition and wider coverage needed'* From the Equality Impact Assessment: 'D.11 does not seem to have any corresponding specific guidance and seems somewhat separate from surrounding material on communicable diseases and safe and hygienic practice premises. This is exacerbated by the fact that guidance on impairment of mental or physical health appears only in the section on integrity, positioning the issue as one of non-disclosure. The emphasis seems to be towards osteopaths with a mental or physical impairment being unable to practise or necessarily restricted in their practice. This may be unhelpful, including in relation to the duty to promote positive attitudes towards disabled people."	Fitness to practise – the guidance at paragraphs 27 and 27.1 to 27.3, which supports standard D14 was thought to be in the wrong place. D14 requires an osteopath to act with integrity and the guidance relates to an osteopath's health and fitness to practise.	It was agreed that the guidance at paragraphs 27 and 27.1 to 27.3 should be moved to support standard D11. standard D11 should be moved so that it appears before the current standard D10. Paragraph 25.1 of the guidance supporting the current standards D10 to D13 should be moved to support D11 in its new position.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
D14/D15	'D14 and D15 generated a significant response, with requests for clarification on issues of advertising and publicity, financial disclosure including fees for referral; e.g. in standard D15 guidance 31, many respondents felt that this statement was either unclear or inappropriate. If it means that there is a requirement to tell the patient what the osteopath's margin on the retail sale (within their practice) of a pillow this seemed inappropriate.'	The guidance is really intended to highlight that any recommendations made to patient should be based on the clinical needs of the patient. This is demonstrated by the guidance and removing some references to financial gain may clarify the concerns raised.	Changes made to D14 and D15 as follows: Delete the following wording from D14 26.6: 'that will bring you financial reward.' Delete D14 guidance 26.8: 'charging unreasonable fees, or failing to provide information about fees and associated costs until these have been incurred.' Delete the following wording from D15 guidance 31 'You must, at the time of recommendation, declare any financial

Standard /guidance	Comment/proposed change	Discussion	Agreed action
			benefit you receive for this.'
D14-17	'A number of comments were also received, about the encroachment of these standards (also D16 and D17) upon the practitioner's private life, with some stating that all references to osteopaths' personal lives should be removed from the guidance'	Issue was discussed by OPS Working Group and reported in the section Upholding the Reputation of the Profession above (pg 30)	Agreed action reported in the section Upholding the Reputation of the Profession above (pg 30)
D14 guidance 27, 27.1 to 27.3	Fitness to practise – 'focussing on the guidance provided at 27 and 27.1 to 27.3, it was noted that this did not provide guidance on what an osteopath should do when they have less serious illnesses, such as influenza.'	It was **agreed** that this guidance and guidance on what an osteopath should do when in a pandemic situation should be considered for supplementary guidance. It was also felt that as this involved the health of the practitioner, that the guidance would fit better under D10.	Consider the issue of communicable diseases for supplemental guidance. The guidance on communicable diseases has now been moved to D10.
D 14 guidance 26.8 & D15 guidance 30	'26.8 & 30 in section D could be combined'	It was agreed that the guidance in 26.8 and 30 was similar and provided unnecessary duplication.	D14 guidance 26.8 removed.
D16 guidance 36.6	An issue was raised with the GOsC affecting osteopaths human rights with the statement: '*This applies even after they are no longer in your care'.* This would interfere with the private life of an individual.	The CHRE's publications on sexual boundaries makes it clear that research shows that a patient may be harmed as a result of a sexual relationship with his or her former healthcare professional, however long ago the professional relationship ended. The CHRE's full package of guidance in this area has been	No change to OPS but further communication of CHRE's publications on sexual boundaries to the profession.

Standard /guidance	Comment/proposed change	Discussion	Agreed action
		publicised to the profession in this past. It should be publicised again when the new Osteopathic Practice Standards are published.	
D17	Upholding the reputation of the profession through your behaviour. Osteopaths expressed concern that this standard went too far and it was considered by some to be irrelevant to patient safety or clinical care.	Issue was discussed by OPS Working Group and reported in the section Upholding the Reputation of the Profession above (pg 30)	Agreed action reported in the section Upholding the Reputation of the Profession above (pg 30)

General

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
General	'It was often suggested that case studies/examples/definition were needed. Although we understood and fully appreciated these points our opinion was, and remains, that this document is not the place for such things. However, we do feel that there would be considerable value in making this provision with perhaps the addition of frequently asked questions (which could be a 'live' document). This may of course fall more within the remit of a professional body rather than the regulator'	Whilst this may provide clarity, case studies and examples will generally be covered by supplemental guidance and training materials where necessary. There will also be further development over the next few months to ensure that the messages within the Standard and Code are clearly communicated.	Further development work on supplemental guidance and implementation of OPS.
General	'There should be a definition of standards and guidance'	Agreed that this would improve clarity.	Text to be added to introduction.
General	'An index of key terms and where guidance on them can be found would be useful.'	Agreed	This will be added when content of document is finalised
General (B&C)	'In both sections B and C, respondents called for GOsC to publish current research, particularly on the safety of specific osteopathic techniques or approaches.'	Whilst relevant, this does not form part of this document	Adverse events research projects to be published separately.
General	'The term ethics (and, for example, related terms such as ethical) are rarely used within the document. Such an approach can be valuable in that ethical considerations are incorporated, appropriately and naturally, into standards relating to the conduct,	Some changes have been made to the headlines for sections B and C to include the word 'ethics'. The guidance needs to be produced in clear language and we consider that this approach would be too abstract for this document.	No change

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
	practice and professional behaviour expected of practitioners. On the other hand, thoughtful considerations about what is 'right/wrong' and/or 'good/bad' may be minimised.'		
General	'Previous consultations have ignored our comments (certainly in Scotland)'	This table addresses the vast majority of individual/group comments. Focus groups/telephone interviews were held in all four regions of the United Kingdom including Scotland	To consider communication of this information.
General	'Sometimes we feel as though we are guinea pigs and if we can manage it then it goes to other professions'	All healthcare regulators are required to outline the standards required of their registrants. There has been a legal duty on the GOsC to publish both a code of practice and standard of proficiency since the implementation of the Osteopaths Act 1993.	To consider communication of this information.
General	'Statement of change on page 22 was not considered by some as particularly helpful, one person felt that it required a huge amount of time to check against the other documents referred to.'	Legal obligation to print – section 13 (3) of the Osteopaths Act 1993 (amended)	As the document has changed so much, changes are described in generic terms.
General	'100% of the respondents said that to meet all of the standards whilst working 'pitchside' would not be possible, although we did not get a large amount of feedback (to our knowledge there were actually only two respondents involved in this area)'	We cannot lower standards for those working pitchside. We need to find a way for osteopaths to achieve and this may require additional guidance. We need to explore this area further before making comment	Undertake further communication with those working in this field to explore whether any further guidance is required
General	'It was felt (by some) that use of the word	Discussed by OPS Working Group and reported	Agreed Action

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
	'should' and by everyone that use of the word 'must' in the guidance made it prescriptive. It was considered that the word 'must' was inappropriate for guidance'	on in Distinguishing Standards from Guidance section above (pg 10)	reported in Distinguishing Standards from Guidance section above (pg 10)
General	'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'	This is patient expectation to be managed by the osteopath. The Standard and Code should not seek to define the treatment provided to patients as this would be outlined by a scope of practice	No change
General	'Respondents felt that it would be helpful to have more links to other websites, to access relevant information on standards and legal requirements (e.g. data protection, advertising standards, health and safety, financial records), although a small number suggested that where standards were part of the (national) legal framework they were superfluous to this document and the statements should be removed'	References within the document would not be able to be updated as and when they change. This will be addressed through links on website and supplemental guidance where necessary	To be dealt with through website and supplemental guidance
General	'We were regularly told that this document '*seems like another stick to beat us with'; 'it is another means to hang us'* and '*lawyers will be able to use this against us'.* On many occasions the comment was made '*this is all about the protection of the patient – what about us?'* '	Hewell Taylor Freed: We have commented above that there does perhaps have to be further promotion/provision of information about the regulator's role and we would repeat that again here. In addition we found it very surprising that many osteopaths did not seem to appreciate that in protecting patients this	Action: communication of role of the regulator.

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
		also protected them. We recommend that some actions need to be taken to explain this fully but simply, and for it to be a continuous and on-going message.	
General	'It is ludicrous that educationalists have not been involved in the development process as this needs to form the basis of the education they provide'.	Both undergraduate and postgraduate educational institutions were consulted during this development of both the code and standard. Each was offered a telephone interview. The aim of the document is to provide standards of practice for osteopaths. Whilst this document defines the outcomes required at the end of an osteopathy course, it is not intended to define criteria for educational courses. Currently these are covered by the QAA Subject Benchmark Statement for Osteopathy	Communication issue – participation in GOsC work.
General	It was felt that each situation an osteopath faces is unique and that the current code of practice recognises this. It was also felt that the current code acknowledges the osteopath's ability to deal with complex situations. The majority of the group were of the opinion that that the new document does not cover either of these two points adequately.	Whilst every situation may be unique, the code/standard should be constructed in a way that covers all situations. This requires a more high level document which states the basic standards that osteopaths have to meet and that gives guidance on the best way this can be achieved whilst still offering flexibility for an osteopath to exercise their judgement in different situations. To have a highly complex code/standard would	No change

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
		have several effects: it would limit the flexibility of judgement which an osteopath could have in specific situations; it would make the document unwieldy and not user friendly and thus it would be less likely to be used by osteopaths and patients. Supplemental guidance can be produced for any part of this document where it is considered necessary – this would be more targeted and could be updated more quickly when circumstances change rather than having to await a review of the main document	
General	'Other codes e.g. NMC, GMC are far less prescriptive'	This version is far less prescriptive than the existing code/standard for osteopaths	No change
General	Would like to have an additional document which is 'chattier' than the guidance. This would be particularly helpful for section D as good examples could be provided in this type of document	Supplemental guidance would address this requirement in areas that require further explanation	Supplemental guidance where necessary
General	'On the whole it is clear, though there is uncertainty, however, about its relationship with the "scope of practice" document.'	Scope defines the range of osteopathic practice rather than the standard of that practice.	Communication issue - explanation of how this fits with the scope in promotional material.
General	The OPS Working Group suggested a need to communicate clearly to osteopaths that private lives impact on professional lives.	As a result of the discussion on Upholding the Reputation of the Profession.	To be considered as a communication issue.

Format

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
Format	'The layout and format of the document was generally liked. Ninety per cent of all respondents liked the format, with 83% of those who added comments on what they liked about it expressing support for the document's clarity and conciseness, use of language and the visual layout.'	General support from all stakeholder groups	Format to remain as it is drafted
Format	'The document is comprehensive and well set out. Deciding the format and structure is commonly problematic as some standards and guidance can 'fit' into more than one theme, especially in matters of ethics. Generally, the theme names are well chosen and each contains appropriate standards and guidance. But this sometimes means that 'full' ethical consideration is addressed across more than one theme. Examples include: • Consent – is addressed in both themes A and D • Confidentiality (as addressed in D) is also important ethically for the trust within the patient partnership • Communication skills are well described in A but of course are also important skills for reference in B	Strategies to cope with this include: • Cross referencing • Mapping to show links • Including guidance that themes are not self contained so that the themes, standards, code of practice and guidance need to be read as a whole rather than by cherry picking.'	Format to be reviewed once content agreed.

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
	• Guidance and standards connected with patient records are addressed in A, C and D • Treatment plan is referred to in both A and C. Strategies to cope with this include: • Cross referencing • Mapping to show links • Including guidance that themes are not self contained so that the themes, standards, code of practice and guidance need to be read as a whole rather than by cherry picking.'		
Format	'Many commented that they really liked the two colours as they felt it added to the clarity of the document. Others commented that the colours used were in fact very similar; this created difficulties when printed off in black and white and also for anyone who is colour blind.' From the Equality Impact Assessment report: 'It is possible that the colour contrast of the document will not be sufficient to distinguish between the standards (blue) and the code of practice (purple) for people who are colour blind or have other types of visual	Whilst general support from all stakeholder groups, need to ensure that we have adequate versions to deal with colour blindness in order for document to be accessible.	Use of colour/alternative versions to be considered as part of design and publication of document

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
	impairment. Alternative formats should be available on request (Hewell et al, page 9).'		
Format	'Will the document be produced in different languages for overseas-trained practitioners, for whom English is not their first language?'	The GOsC has a Welsh Language Scheme. It does not intend to publish in other languages.	To consider whether we are required to publish in Welsh.
Format	'A substantial number did feel that it might assist the clarity of the document if the 'standards column' was all shown in a bold typeface.'	This change will help ensure clarity.	Standards to be shown in bold type.
Format	'100% of the focus group attendees commented on the fact that the numbering of the document goes somewhat awry and this needs correcting. In addition, the vast majority of those attending focus groups said that it was sometimes difficult to be absolutely clear which standards the guidance related to and this comment was also made by many of those who completed telephone interviews. Different numbering system would make them clearer e.g. restart the guidance numbers for each standard so that the relationship is obvious'	Need to ensure clarity in referencing of guidance so that it matches standards.	Referencing for guidance to change to mirror the referencing used for the standards to improve clarity.
Format	'The document should be reviewed to identify points where internal cross-referencing is needed. For example, the remarks about monitoring quality in the guidance linked to standard B4 on p.9 and those on information in the guidance on standard D3 on p.14'	Cross-referencing would improve clarity.	Cross-referencing to be added where appropriate.

Standard /guidance	Comment/proposed change	Discussion	Agreed Action
Format	'The format was seen as well-laid out in general; except that on page 6, because of the large number of guidance points the link with the relevant standard was not immediately visible. This is easily remedied by simply repeating the standard on page 6'.	To produce revisions and review if this is still necessary.	To address formatting changes after content agreed.
Format	'I think that clause 16 which starts on page 12 and continues on page 13, should start on page 13 so that its whole clause can be more easily read and digested.'		To be addressed when final version is formatted.

Additional

Additional	Additional guidance regarding private medical insurance company attitudes and policies, patient complaints procedures and how to deal with refusing treatment (i.e. are there set GOsC algorithms) would be helpful.	To be explored.	To be explored.
Additional	How many complaints does GOsC have, and how many of those relate to communication and how many are upheld?'		GOsC publishes an annual fitness to practise report (available on the website) which details all cases upheld.

List of potential subjects for supplemental guidance to the Osteopathic Practice Standards

142. The following have been identified as potential areas for supplemental guidance. These will be considered by the GOsC in terms of the necessity:

a. Clinical hygiene
b. Communicable diseases, including HIV
c. Consent
d. How to collect and analyse data
e. Modesty of dress and restrictions to treatment
f. Pandemics
g. Pitchside guidance
h. Referral pathway for safeguarding children and vulnerable adults
i. Risks and communicating risks – the results of the 'adverse events research'
j. Specific guidance for sole practitioners

Recommendations from Hewell Taylor Freed & Associates in relation to consultation methods employed by the GOsC

143. Hewell Taylor Freed & Associates make a number of recommendations on how to improve the way in which the GOsC consults. These can be found in the section 6 entitled 'Thoughts and recommendations' on page 56 of the consultation analysis report. The GOsC is committed to consulting with a wide-range of different groups of people affected by the work it carries out – its stakeholders. To this end it strives to improve its methods of communication and consultation and will use the feedback from Hewell, Taylor, Freed & Associates Ltd to improve its future work.