



New Graduates' Preparedness to Practise

Research Report
of a study commissioned by the
General Osteopathic Council

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Abbreviations

BOA	British Osteopathic Association
CBI	Confederation of British Industry
CILP	Critically Intensive Learning Period
CPD	continuing professional development
c.f.	compare with
EBP	evidence-based practice
GP	General Practitioner
GOsC	General Osteopathic Council
OEI	Osteopathic Education Institution
QAA	Quality Assurance Agency for Higher Education
QMUL	Queen Mary University London
S2k	Standard 2000: Standard of proficiency
UK	United Kingdom
UUK	Universities UK
viz	namely

Labelling of quotations

C/E	Colleague or Employer
Faculty	OEI staff, including clinic tutors
FYS	Final year student
MOD	Focus group moderator (researcher)
NR	New Registrant
PAR1	Focus group participant 1
(sic)	used to indicate that what precedes it is written intentionally or is copied verbatim from the original, even if it appears to be a mistake
...	Pause for thought in spoken contribution to focus group
[...]	Extraneous material removed from written submission
[name]	Identifying elements removed from written submission
[word]	Clarification through insertion of missing word

Statistical symbols and abbreviations

χ^2	chi-squared
df	degrees of freedom
p	probability

Executive Summary

This study about the preparedness to practise of recent osteopathy graduates was commissioned by the General Osteopathic Council (GOsC), which regulates the practice of osteopathy in the UK. It was conducted between March and December 2011. The study examined perceptions of preparedness to practise among four key stakeholder groups:

- osteopaths who first registered with the GOsC in 2009 or 2010, termed '**New Registrants**';
- more experienced osteopaths (first registered before 2008) working in the same practices as the New Registrants, termed '**Colleagues and Employers**';
- **final year osteopathy students** (UK OEIs); and
- selected **staff at Osteopathic Education Institutions** (UK OEIs).

Online questionnaires were used to collect data from New Registrants and Colleagues and Employers. Focus groups were used to gather the views of faculty and final year students. Some individual interviews were conducted for study participants who could not attend a focus group (see Chapter 2 for details of data collection and analysis). The New Registrants' questionnaire survey yielded 127 responses (response rate 24.5%). Most respondents (81%) were self-employed and just over half (55%) worked in group practices. A minority (14%) reported additional healthcare qualifications. The Colleagues' and Employers' questionnaire survey yielded 61 responses (response rate 15.7%). The median duration of practice for this survey's respondents lay in the interval 16-20 years, so most were very experienced osteopaths: 72% were employers or lead practitioners in a group practice. Respondents' practices were small, the majority (64%) having two to four osteopaths. Most experienced osteopaths responding to the Colleagues' and Employers' Survey reported that, at that time, they worked alongside only one New Registrant.

Demographic and employment related characteristics of questionnaire respondents were compared with the wider population of GOsC New Registrants to examine the degree to which respondents could be considered typical. Generally, they could be considered typical. The two most important differences to emerge were that New Registrants who participated in this study tended to be older than the wider population of New Registrants; while examination of responses to the Colleagues' and Employers' questionnaire showed that experienced osteopaths working alongside graduates of the British School of Osteopathy were over-represented. Further details of the profiles of study participants in each of the stakeholder groups can be found in Chapter 3.

By definition, the Colleagues' and Employers' Survey focused on New Registrants who worked in group practices. It did not seek professional opinions about the preparedness of New Registrants who became 'single-handed' or 'lone' practitioners, although we received some comments about this group.

Focus groups or interviews were conducted with faculty and final year students from six of the eight Osteopathic Education Institutions (OEl)s which had graduates in 2009 or 2010. We do not know the extent to which focus group participants were purposefully selected by OEl key contacts, or simply convenience samples.

Study findings were divided between six chapters, which will be summarised in turn. Within these, Chapters 4-7 examined different facets of osteopathy graduates' preparedness to practise: clinical knowledge, skills and competence; interpersonal and communication skills; business and entrepreneurial skills; professionalism. These things are intertwined and it is often difficult to consider one facet without including another. Chapter 8 outlined mechanisms that study participants identified as ways to support osteopathy graduates' transitions to practice. Chapter 9 presented three emergent, cross-cutting themes.

Chapter 4: Clinical skills, knowledge and competence

Competent clinical practice requires the seamless integration of clinical knowledge and clinical skills with well-developed interpersonal and communication skills, professionalism and sound business practices. Consequently, Chapter 4 expands beyond clinical skills and knowledge to include some more integrated views of New Registrants' clinical competencies, and comparisons of relative strengths and weaknesses in different areas of professional practice.

Study participants (New Registrants, their colleagues and employers, final year osteopathy students and OEl faculty) regarded New Registrants' up to date knowledge as their most important asset. Their clinical skills were thought to be sufficiently well developed to support safe practice. Variability and uncertainty were evident across the data, from multiple perspectives. The early months of New Registrants' were described in ways that suggested a period of consolidation, refinement and expansion of clinical skills; resulting in more confident clinical practice which better integrated clinical skills and knowledge with other aspects of professional practice, such as holistic patient management and knowing when to seek input from others. Study participants' characterised New Registrants' initial practice as likely to be 'safe, if not always effective'. This was because effectiveness was regarded as multifaceted, including areas in which New Registrants needed more experience and development. For example, effectiveness was characterised as extending beyond technical clinical matters of osteopathic techniques, clinical skills and the application of appropriate clinical knowledge, to encompass discerning selection of tests and interventions alongside holistic patient management. Colleagues and Employers reported that New Registrants were often insufficiently incisive in their clinical reasoning and struggled to develop adequately patient-centred case management plans; leading to insufficiently selective choices of investigations and interventions. The main assumption of study participants from all stakeholder groups appeared to be that refinement and expansion of expertise would flow from engagement in clinical practice. Some experienced

osteopaths enjoyed working with and supporting New Registrants, while some found this undesirable or too great a burden.

OEI faculty reported that osteopathy degrees' emphasis on clinical education was intended to support *safe, independent* practice. This emphasis on independence was a response to the prevalence of self-employment and isolated practice among New Registrants. It also linked to the value which osteopaths placed on autonomy (a theme that was developed further in Chapter 9).

One theme that was unexpectedly missing from faculty and student data sets was consolidation of clinical learning within OEI programmes. However New Registrants were generally positive about their degrees: the most notable exceptions were some ambivalence about the quality of clinic-based learning and the consistency of clinical assessments.

Many experienced osteopaths enjoyed working with New Registrants, who were regarded as possessing important knowledge, skills and enthusiasms; whilst also needing support and mentorship. Some respondents described 'expansive' learning environments in which the whole practice learnt as a result of the presence of a New Registrant. However, some stressed that New Registrants' needed to be self-sufficient because colleagues lack the capacity to provide support.

Exploration of a 61% to 39% division between Colleagues and Employers who considered that New Registrants were sufficiently (51%) or well-prepared (10%) to practise, and those who doubted their preparedness, found substantially overlapping views of New registrants' strengths and weaknesses. This indicated that they were underpinning their judgements by grading on broadly similar spectra of clinical and personal characteristics: the difference lay in calibration (something which is likely to be influenced by respondents' dispositions and variation in the quality of New Registrants).

Final Year Students were looking forward to commencing professional practice, feeling that had sufficient knowledge and basic clinical skills to do this safely. They expected to 'learn from experience' and engage with CPD from the beginning of their careers; thereby increasing their expertise and effectiveness. They seemed to have accepted the prevailing discourse that New Registrants' practice would be 'safe, but not necessarily effective'. A possible disadvantage of accepting this discourse could be reduced drive towards increasing their effectiveness prior to registration. However, important advantages include a strong focus on patient safety and recognition of the ongoing need to improve one's professional performance.

The most striking feature of New Registrants' reports of the strengths and weaknesses in their clinical knowledge was its diversity: over sixty areas of confidence were named and over 100 areas of limited confidence were identified. Almost every area of confidence named by a New Registrant was also named by another as an area of limited confidence. The pattern for clinical skills was similar. This diversity was linked to variability and uncertainty experienced by Colleagues and Employers working alongside New Registrants.

Chapter 5: Interpersonal and communication skills

Interpersonal and communication skills, as well as being a focus in their own right, underpin the clinical competencies discussed in Chapter 4 and entrepreneurial and business skills (Chapter 6) and professionalism (Chapter 7). New Registrants were positive about their preparedness for the interpersonal and communication aspects practice. In addition to learning during their osteopathy degree, some New Registrants emphasised how much they had learnt during the careers they pursued before osteopathy.

It was clear that New Registrants' interpersonal and communications skills development had continued in the early months of practice. For example, several indicated that, having initially been prone to over-optimism, they were developing ways of communicating more realistic assessments of what osteopathy might achieve, and how long and difficult the process might be. New Registrants provided a diverse range of examples of situations in which their interpersonal and communication skills had served them well, and similarly, situations when they felt they needed better interpersonal and communication skills. Recurrent themes were extracted, which could help guide curriculum development and postgraduate support.

Colleagues' and Employers' evaluations of New Registrants' interpersonal and communication skills were a little more muted. They felt New Registrants' interpersonal and communication skills were less well developed than clinical knowledge and skills, but better developed than business skills. They also felt New Registrants were most skilled when working with patients and least skilled when working with other professionals (as opposed to their direct colleagues). Most felt that New Registrants could explain treatments to patients in ways which were accessible and understandable. However, most had reservations about New Registrants' responses to patients' anxieties, frustrations and pain; their management of challenging situations and liaison with other professionals.

Within OEs, the importance of communication skills for patient management and accurate clinical intervention was expressed, however, more weight was given to safe clinical practice and the pragmatics of how best to elicit information to support diagnosis. Building relationships as a component of patient management or the skills needed to communicate with other professionals appeared to receive less attention. Specific interpersonal skills learning, was seemingly left more to chance and exposure to observations in clinic. The assumption that observation of clinic tutors will lead to good role modelling may in some cases be true, but not in all cases, as noted by some students. Feedback from clinic tutors was patchy.

The narrative relating to clinic learning was typified by levels of uncertainty and the identification of variation: a manifestation of the emergent theme of Diversity, Variation and Uncertainty (Chapter 9). The uncertainty for students centred on the development of interpersonal skills as being left to chance by observation of clinic tutors and more senior

students. Another major issue was how to ensure consistent teaching in the context of: unpredictability surrounding the range of patients a student might meet in clinic, and variation in tutors' abilities to demonstrate and apply interpersonal and communication skills. Final year students felt academic and clinic teams assumed students would "*Learn by osmosis*" from observations and exposure to the clinic environment. The reality for students was of mixed experiences – from the very good, to awful.

Though there were some examples of strategic approaches to developing interpersonal and communication skills, the collective voice was that of uncertainty. From a faculty perspective the development of these skills was seen as imperative, but delivery was challenging. Curriculum content for interpersonal and communication skills could feel like a bolt-on extra, lacking integration with other parts of the curriculum. Some OEI's recognised this and were actively seeking to develop their curriculum strategy or the pedagogic expertise of faculty whose classes and clinic sessions contributed to the development of students' interpersonal and communication skills. OEI's may need to consider further how they train and support clinic tutors to ensure they are modelling best practice and giving effective feedback. However, New Registrants' were mostly positive about their degree level preparation, so there is much that is positive to build upon.

Students expressed concerns about their preparedness to practise with respect to patients with support needs related to mental health or mental capacity. Some OEIs had begun to explore ways to meet these learning needs, but, provision was patchy.

Chapter 6: Entrepreneurial and business skills

New Registrants needed to build successful small businesses, in difficult economic conditions, under pressure from debt accumulated whilst studying, whilst honing and extending their clinical and interpersonal skills. This was never going to be easy, but realistic expectations and awareness of important principles were likely to help. Study participants emphasised that increased preparedness for running a small business could not be at the expense of developing clinical competences: safe and reasonably well-accomplished clinical practice needed to be achieved.

Although Colleagues and Employers made many criticisms of New Registrants' entrepreneurial and business skills, they appreciated New Registrants' enthusiasm and new ideas for building their businesses. Colleagues and Employers suggested that more could be done during osteopathy degrees to develop realistic expectations of the hard work involved in building and maintaining a patient base. They drew attention to the variability of New Registrants' business acumen, based both in personality differences and in career histories. In summary, Colleagues and Employers felt graduates needed:

- better understanding of how referral networks function and the importance of interpersonal skills in maintaining or fracturing relationships with patients;

- better presentation skills;
- to be better at formulating treatment plans with short- and long-term goals and a regular tempo of improvement.
- New Registrants were reasonably good at promoting osteopathy in interactions with GPs but perhaps overlooked similar opportunities with non-medical practitioners.

New Registrants found the transition from student to engaging with the business of osteopathy challenging: 61% of respondents provided examples of the business-related challenges they had faced. Nevertheless 55% were able to give examples of things they had done well to enhance their osteopathic business. There were diverse experiences and varied perceptions. Learning needs named by some respondents were likely to be named by others as things they had done well. Although most students graduated feeling “safe” and therefore well prepared for clinical practice, their position as commercially astute practitioners was more precarious. In relation to other parts of the curriculum, during their osteopathy degrees business had been seen as a less important learning focus: particularly in view of the emphasis on patient safety reported in Chapter 4. Some New Registrants felt tensions between the necessity to earn money and: their feelings of self-worth, their preference for a service-orientation to healthcare, and potential conflict between business practices and ethical practice. It was noted that not everything can be taught in advance of experience and, while New Registrants might begin with “rough skills”, these are refined through the experience of joining or starting up an osteopathy business.

Many New Registrants become osteopaths after working in other small businesses, finance or marketing, for example: these brought more realistic expectations of business and some relevant business skills. In addition, some New Registrants’ reported that their earlier careers and hobbies had provided a focus for marketing their new osteopathy practice to people whose needs they could better understand. Their challenges focused on: developing more realistic expectations; financial and legal matters; marketing; setting up a business; the slow and effortful process of building a patient base; isolation and avoiding unfair business practices and ‘scams’.

There was great uncertainty about the business curriculum and provision varied noticeably across the OEIs. The ‘Holy Grail’ for faculty was to find the best way to include entrepreneurial and business education, without undermining clinical learning, and such that students would attend activities and evaluate these positively. Discussions centred on timing, level and content. Faculty were struggling to make business education feel “live” at appropriate points in the curriculum. They appeared rather reliant on their own knowledge as practising osteopaths and entrepreneurs, or inviting guest speakers. This approach yielded mixed results. Mature students who had previously been self employed or worked in business environments, felt that they had something to offer as learning agents, often over and above the guest speakers; but faculty did not mention harnessing this expertise within student cohorts.

There was no clear strategy for using clinic experiences to prepare learners for business. Differences in in-house clinic operations could both help and hinder the ability to be more business aware. When students gained experience in specialist clinics, NHS services and social care, or with charities, these were framed as wider access to pathologies not necessarily seen in 'mainstream' clinics, overlooking the possibility that these clinic environments also prepared students for interprofessional and interagency engagement, which could support business development. This study did not encounter any faculty or student narratives around the interconnections between business and patient management. It seems that clinic education could be better-developed.

Students' evaluations of business learning varied from satisfied to very unsatisfied, both in terms of quality and the timing of business-related elements in the curriculum. They had mixed views about the relevance of business skills early in the programme, mainly feeling that this was an unnecessary component compared to osteopathy, but also recognising it was unrealistic to turn attention to entrepreneurship and business skills only in the final months of the course. Final year students were anxious that business education in college was just an introduction, leaving much self-directed and experiential learning to be completed as New Registrants. Final year students also felt tensions between being an osteopath and being business savvy in order to make a living. Hopes of being a good practitioner tended to override being good at business, leading students to downgrade the importance they gave to business-related education. However they worried about whether they were at risk of being outmanoeuvred by other therapists with more business-focused education and better presence in the marketplace.

Chapter 7: Professionalism

Professionalism is a complex and diffuse concept, which does not stand aside from other aspects of expertise, but rather infuses these with values, attitudes and actions that are patient-centred and empowering, collaborative, ethical, self-aware and aligned with osteopathic values and principles. Consequently we touched on aspects of professionalism in earlier chapters, particularly: the emphases on safety and communication with patients within clinical education; noting variable preparedness for interprofessional collaboration with other healthcare professionals; also recognition of the interplay between professional behaviours and building a successful osteopathic business. In Chapter 7 we summarised data pertaining to additional aspects of professionalism, viz: osteopathic values, standards for practice, evidence-based practice, engagement with continuing professional development, reflective practice and self-evaluation.

There was no consensus about osteopathic values, rather a diversity of perspectives which linked to two emergent cross-cutting themes which will be addressed in Chapter 9: firstly, Diversity, Variability and Uncertainty and secondly, Autonomy and Isolation. Awareness, but limited understanding, of slightly different preparations for practice provided by

different OEs appeared to lead to some segmentation of employment opportunities. In the context of slightly different emphases in osteopathy degrees, GOsC Standards for Practice were important to ensure common thresholds for preparedness to practise. The Standards were embedded in osteopathy curricula, partly due to accreditation requirements, but also because faculty were preoccupied with preparing students for autonomous, independent practice; due to the high prevalence of self-employment and lone practitioners. From the OE perspective, the S2K standards drove learning and assessment, and embedded a sense of professional behaviour in learners from the earliest stages of the programmes.

All stakeholder groups expressed high levels of certainty that New Registrants were familiar with the GOsC Standards for Practice. Responses in relation to the use and usefulness of the standards in daily practice were more muted but still generally supported. Both students and New Registrants were most exercised about the Standards relating to communicating risks and benefits, and ensuring consent.

Consideration of evidence-based practice (EBP) prompted discussion of different understandings of the nature of evidence in relation to osteopathic practice and some concern about the role of EBP in enhancing or damaging the profile of osteopathy as a valid alternative to medicine and manual therapies such as physiotherapy and chiropractic. Students and New registrants were confident about their understanding of EBP, but highlighted a gap between understanding and the ability to enact EBP in daily practice. They and faculty highlighted the poor availability of evidence (however defined). This had two components: firstly, osteopathic evidence was felt to be in particularly short supply. Secondly, students and New Registrants were concerned about rather limited free or affordable access to bibliographic databases and journals, once they graduated. Study participants identified the physiotherapy literature as a fruitful source of evidence to support osteopathic practice.

Professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. The great majority of respondents to the New Registrants' Survey reported that were confident (or very confident) they could recognise their strengths and weaknesses: arguably the essential first step in self-monitoring. However, data from the Colleagues' and Employers' survey highlighted variability: individual variability in self-awareness and, at aggregate levels, variability across different areas of professional practice. For example, in aggregate, Colleagues and Employers concurred with New Registrants' positive evaluations of their knowledge base and commitment to osteopathic values, but felt New Registrants over-estimated the quality of their treatment planning and interpersonal skills. Within osteopathic education programmes the main activity associated with self-evaluation and commitment to career-long learning was the promotion of reflective practice, although this had a relatively short history at some OEs. This study found high rates of participation in CPD (greater than 80%), even among those in their first post-degree year and, therefore, exempt from GOsC CPD requirements. Respondents provided a very wide range of examples of CPD participation, mainly focused

on additional clinical skills and related underpinning knowledge in order to expand their repertoire of diagnostic and treatment skills, most often cranial work or acupuncture; some focused on developing their expertise with respect to specific patient groups, most often children; while some had focused on business-related CPD. Self-study, attending practice-based CPD and local and regional CPD groups were all popular, reflecting New Registrants concerns about the cost of many CPD opportunities. Nevertheless many had attended short-courses or conferences, or undertaken more substantial programmes of study, sometimes leading to additional qualifications.

Chapter 8: Supporting osteopathy graduates' transitions into practice

This chapter explored accounts of transitions into practice and identified mechanisms for supporting New Registrants. Good quality clinic and placement learning during osteopathy degrees was needed to form the initial foundations of clinical practice. Perceptions of current provision were described in Chapter 4 and the importance of role modelling by clinic tutors was highlighted in Chapter 5. In Chapter 8 we added a summary of Colleagues' and Employers' priorities for strengthening clinical education in osteopathy degrees

After graduation the most widely practised and least contentious form of support was mentorship, which was valued by all stakeholder groups, although experiences of mentorship were very variable. Mentorship was often ad hoc: the focus tended to lie with immediate support needs, rather than systematic development of New Registrants' practice, and with clinical matters much more than practice management or business development. New Registrants sought and received mentorship from many sources, most often practice principals, immediate colleagues and former OEI tutors. New Registrants who practised alone received less mentorship. Sustainability and quality were the primary concerns of study participants in relation to any extension of mentorship. Some worried about oppressive oversight, loss of autonomy and increased potential for exploitation if the profession moved towards more formal mentorship. There was limited support for a period of conditional registration or a structured foundation period. Many practising osteopaths preferred to support transitions to practice by strengthening clinical education during osteopathy degrees.

A high proportion of New Registrants engaged with CPD from the very beginning of their careers to fill knowledge gaps, extend their expertise and consequently their service to patients, and to build confidence. Study participants highlighted the value of working in group practices and multidisciplinary environments to achieve the same outcomes.

We found that OEIs and faculty continued to support their former students after graduation and this provision seemed likely to expand, although there were concerns about sustainability and inequality.

Chapter 9: Emergent and cross-cutting themes

Three major cross-cutting themes emerged in the preceding chapters: 'Safe, if not always effective', 'Diversity, Variability and Uncertainty' and 'Autonomy and Isolation'.

Exploration of the discourse of 'safe, if not necessarily effective' showed it to set thresholds for clinical education and assessments that focused on safety, possibly to the detriment of other aspects of osteopathic practice such as developing osteopathic reasoning, interpersonal skills and business acumen. Beyond the obligation of all professions to safeguard the public, the main drivers for great emphasis on safety were the high incidence of self-employment and patchy mentorship for New Registrants. However, the result was considered to be an over-cautious and insufficiently discriminating style of practice among New Registrants, which limited their effectiveness and left much to be learnt during the initial months of practice. It was suggested that greater attention to consolidation of a range of clinical competences during the final months of degrees would be beneficial.

Diversity and variability were identified throughout the journey from student to competent practitioner. Student cohorts could be very mixed, with a large proportion of mature students with diverse past careers and life experiences. Faculty sometimes struggled to match the curriculum to everyone's needs. However, clinic and placement education during degrees, and the mentorship of New Registrants, were perhaps the most significant sites of variability; leaving some feeling well-prepared and well-supported while others had much more difficult experiences. Clinic and placement education varied between OEIs and, even within each OEI, clinical assessments were regarded as somewhat variable. Following graduation, experiences of employment conditions, mentorship and other support for development during the early months of practice were all very variable. It was impossible to identify a 'typical' trajectory for a new Registrant, perhaps apart from reality shock in relation to the long and arduous process of building a patient base. Nevertheless, diversity was prized as a facet of autonomy.

Autonomy was both central to the self-image of osteopaths and simply a commercial necessity: independent, possibly isolated, practice was the only option for many. Consequently, osteopathy degrees emphasised safety, self-evaluation and self-reliance. Some New Registrants then bridled at restrictions to their autonomy from regulations and practice principals. However, most New Registrants desired more structure and support during their early months in practice. This did not always sit well alongside colleagues' expectations that they should be proactive and fairly self-reliant, but seek help when required as a manifestation of autonomous self-evaluative practice. The high value placed on autonomy could make it difficult for practitioners to ask for help or advice. Many New Registrants, including those working within group practices, expressed a sense of isolation during their early months of practice.

Chapter 10: Discussion

Chapter 10 reviewed the study findings in relation to wider literatures concerning workplace learning and the practices of other professions. To support and expand osteopaths' thinking about future directions for structures and processes underpinning osteopathy graduates' preparedness to practise, and their transitions into practice, a wide variety of examples were included and an extensive range of sources of further information were referenced.

For a variety of reasons, preparedness to practise can never be fully complete at the end of an osteopathy degree (or any profession's pre-qualification education). This is predominantly because practice is highly variable and constantly evolving, and certain aspects of professional learning have to occur through engagement in workplace practices. This was not fully recognised by the osteopaths in this study, although we discovered a strong discourse of 'safe, if not always effective'. This represents recognition that new graduates have passed a certain threshold (safety) and can now begin unsupervised practice, but still have much to learn. Study participants reported a surprising variety of strengths and weakness among New Registrants, although gaps in business and entrepreneurial skills and patient management skills were very commonly reported. The emphasis on safety within osteopathic education resulted in lower priority being accorded to interpersonal and communication skills (which are also difficult to assess) and preparation for business. In this chapter we included several examples of ways in which other professions have approached the development and assessment of interpersonal and communication skills. We also examined ways in which the development of interpersonal and business expertise might be better integrated within elements of the curriculum that primarily address clinical skills.

Many New Registrants struggled with feelings of isolation during their transitions to professional practice. We examined several structures and processes that may support New Registrants' transitions to practice. Numerous examples of approaches and insights from other professions were provided.

It was noted that, although study participants described osteopathy as a manual therapy, medicine was the profession to which participants most often compared osteopathy. In terms of the practice of osteopathy these comparisons almost exclusively positioned osteopathy as different to traditional medicine. However, in terms of structures and processes to support preparedness to practise and transitions to practice, alignment with the medical profession was often regarded as desirable. The structures and processes designed for junior doctors were examined and seen to be untenable for osteopathy. It is likely to be more fruitful to examine the structures and processes used by other manual therapies to ensure adequate preparedness to practise and support during the early months of practice. Other professions that have a relatively high incidence of private practice from early in practitioners' careers, and well-developed structures and processes to support the transition into practice, include veterinary practice, dentistry, optometry and pharmacy. We suggested that it would be useful to examine structures and processes in these

professions to identify those which, with suitable modifications, might be taken up by the osteopathic profession.

Osteopathy graduates who did not seek to become practising osteopaths and therefore, did not register with the GOsC, were excluded from the study: they may well have had different perspectives on the topic of preparedness for practice.

Chapter 11: Summary of osteopathy graduates' preparedness to practise

A simple traffic light system was used to summarise levels of preparedness for different facets of practice: green for a consensus of sound preparedness; amber for facets of preparedness where this study found ambivalence, mixed messages, considerable diversity or a consensus of moderate levels of preparedness; finally red for facets of preparedness where there was a consensus of poor preparedness. This was necessarily an over-simplification of osteopathy graduates' preparedness to practise and ought not to be taken out of the context of the detailed findings reported in chapters 4-9 and discussed in Chapter 10 in relation to the wider literatures concerning workplace learning and transitions from professional education and professional practice. Nevertheless, for convenience, the summary is reproduced here.

Green

Osteopathy graduates' up to date clinical and scientific knowledge was recognised and commended by experienced osteopaths. Adequate underpinning knowledge is a prerequisite for correct clinical reasoning and action, so this is a vital aspect of preparedness to practise.

Osteopathy graduates were considered safe to commence autonomous osteopathic practice.

Graduates were considered to be competent in a limited range of clinical processes and techniques, which could collectively form the basis of initial clinical practice.

Graduates were conversant with Standards for Practice.

Graduates understood and broadly supported evidence-based practice, and could play an active part in continuing debates about the contested nature of evidence in the context of osteopathic practice.

Amber

Colleagues and Employers felt that New Registrants often exhibited insufficiently incisive clinical reasoning and excessive caution, linked to over-investigation or over-treatment, but

they varied in the extent to which they viewed this as indicative of lack of preparedness to practise or an expected and transient part of beginning practice.

Osteopathy graduates interpersonal and communication skills were regarded as less well developed than their clinical knowledge and clinical skills, particularly in relation to communication with other healthcare professionals (as opposed to direct colleagues). Writing letters to GPs was better-developed than other aspects of interprofessional collaboration. Experienced osteopaths doubted osteopathy graduates' preparedness for responding well in challenging situations.

Linked to the previous two areas of limited preparedness, osteopathy graduates were considered to be only partially prepared for developing effective, patient centred treatment plans and promoting self-help.

Red

The data from this study suggested that osteopathy degrees placed such emphasis on safe clinical practice that it displaced attention from other aspects of professional practice. Whilst safety is of paramount importance, it is also important that adequate attention is paid to developing interpersonal skills that are essential for osteopathic practice.

There was widespread concern that osteopathy graduates did not properly appreciate the skills and effort required to build and maintain a successful osteopathy practice. In particular, they lacked appreciation of how small businesses build by word of mouth and the factors that affect this.

Chapter 12: Recommendations

Recommendations were made for four constituencies: the GOsC (section 12.1); practising osteopaths (section 12.2); OEs (section 12.3) and future research (section 12.4). These concerned the following topics:

Recommendations for the GOsC

- CPD requirements during first year of registration
- Supporting access to journals and other resources to support CPD
- Reviewing the practices of other healthcare and wellbeing professions or occupational groups in relation to supporting novice practitioners' transitions into practice.
- Considering the particular needs and vulnerabilities of New Registrants working as lone practitioners.

Recommendations for practising osteopaths

- Regarding high quality support for the development of student and novice osteopaths as a duty of all members of the profession.

- Recognising and responding to New Registrants' transitions to practice (and indeed any practitioner's move from one work environment to another) as Critically Intensive Learning Periods (CILPs).

Recommendations for OEIs

- Reviewing clinic and placement learning
- Examining the rhetoric of 'safe, if not always effective'
- Supporting access to journals and other resources to support CPD
- Examining the rationale and contexts provided for reflective practice
- Strengthening support for the development of high quality interpersonal and communication skills
- Strengthening preparation for entrepreneurial and business aspects of osteopathic practice
- Preparing tomorrow's mentors
- Preparedness for alternative career paths

Recommendations for future research

- Lone practitioners
- Interprofessional perspectives
- Those who leave the profession

Part I: Introduction and research methods

Chapter 1 Introduction

This study about the preparedness to practise of recent osteopathy graduates was commissioned by the General Osteopathic Council (GOsC), which regulates the practice of osteopathy in the UK. The study received ethical approval from Queen Mary University London (QMUL). It was conducted between March and December 2011. The study examined perceptions of preparedness to practise among four key stakeholder groups:

- osteopaths who first registered with the GOsC in 2009 or 2010, termed '**New Registrants**';
- more experienced osteopaths (first registered before 2008) working in the same practices as the New Registrants, termed '**Colleagues and Employers**';
- **final year osteopathy students** (UK OEIs); and
- selected **staff at Osteopathic Education Institutions** (UK OEIs).

Data was not collected from patients: a different project commissioned by the GOsC, the OPEn project,¹ explored patients' expectations of osteopathy. The findings from this study illustrated that patients' expected osteopaths to support individual agency, demonstrate professional expertise and provide appropriate triage and referral, as well as osteopathic treatment. They wanted clear information, an empathic and professional interpersonal relationship that inspired trust and a positive customer experience. New Registrants' preparedness to meet these expectations will be considered in Chapter 10.

In the UK, osteopaths graduate with either a Bachelors or Masters degree, awarded by a university. However, most osteopathic education sits outside mainstream university provision. At the time of the study there were 10 OEIs: two universities and eight independent institutions from which degrees were awarded through validation agreements with universities. Recent approval of a further university department's osteopathy programmes brings the current total to 11 OEIs, still mostly independent colleges. All osteopathy degrees are subject to internal and external quality assurance processes; firstly within each OEI; then, if applicable, through validation and periodic revalidation processes with degree-awarding universities; finally, through periodic review by the Quality Assurance Agency for Higher Education (QAA). The GOsC recognises these quality-assured degrees from approved OEIs as suitable qualifications to permit registration as an osteopathic practitioner, subject to an ongoing commitment to continuing professional development (CPD).² Osteopathic degrees have academic and clinical components. Students are expected to complete a minimum number of hours of clinical experience with a variety of patients and conditions. Most OEIs operate clinics where students are trained, supervised

and assessed for competence by experienced osteopaths. Students may also experience work in independent osteopathic practices and some may experience work in NHS, social care or voluntary sector environments. Those who supervise students in these environments should also contribute to the multiple professional evaluations of students' developing professional competence. Thus the assessment of students' clinical competence is often a partnership between OEI staff and practice-based colleagues. The osteopathy profession needs OEIs to produce knowledgeable, safe graduates, committed to osteopathic principles, with appropriately well-developed practical skills and a commitment to lifelong learning. The external quality assurance of osteopathy degrees focuses on institutional quality processes. At the level of individual students, a wide range of experienced osteopaths need to contribute practice-based and other clinically-focused assessments.

This study was commissioned to examine recent osteopathy graduates' preparedness to practise, recognising that preparedness is multifaceted. Our aim was explore this by comparing and synthesising the perspectives of the key stakeholder groups listed above, *viz*: 'New Registrants', 'Colleagues and Employers', final year osteopathy students and OEI faculty. Their opinions were solicited in relation to five themes: clinical skills and knowledge, interpersonal and communication skills, entrepreneurial and business skills, professionalism and, finally, supporting osteopathy graduates' transitions into practice (see section 2.3.1).

Prior to commencing data collection, the planned foci for the study were discussed and refined with the Regional Communications Network Group (representing osteopath groups across the UK) and the Osteopathic Educational Institution Group (comprising the Heads of the OEIs), and agreed with the GOsC's Research Strategy Working Group which oversaw the research.

Chapter 2 Methods for data collection and analysis

2.1 Overview of data collection

Figure 1 summarises the six main data collection activities: on-line surveys of New Registrants and their Colleagues and Employers, extraction (by a GOsC officer) of anonymous aggregate demographic data from the GOsC Register of Osteopaths, focus group interviews with final year osteopathy students and OEI faculty and discussion with a stakeholder panel. (Telephone interviews replaced a focus group for faculty in one OEI, due to limited availability of faculty on the day of the student focus group.) A small number of additional interviews (face to face and by telephone) were conducted with new registrants and experienced osteopaths to support the development of the on-line questionnaires or to expand upon questionnaire responses. These additional interviews will be mentioned in the relevant sections below.

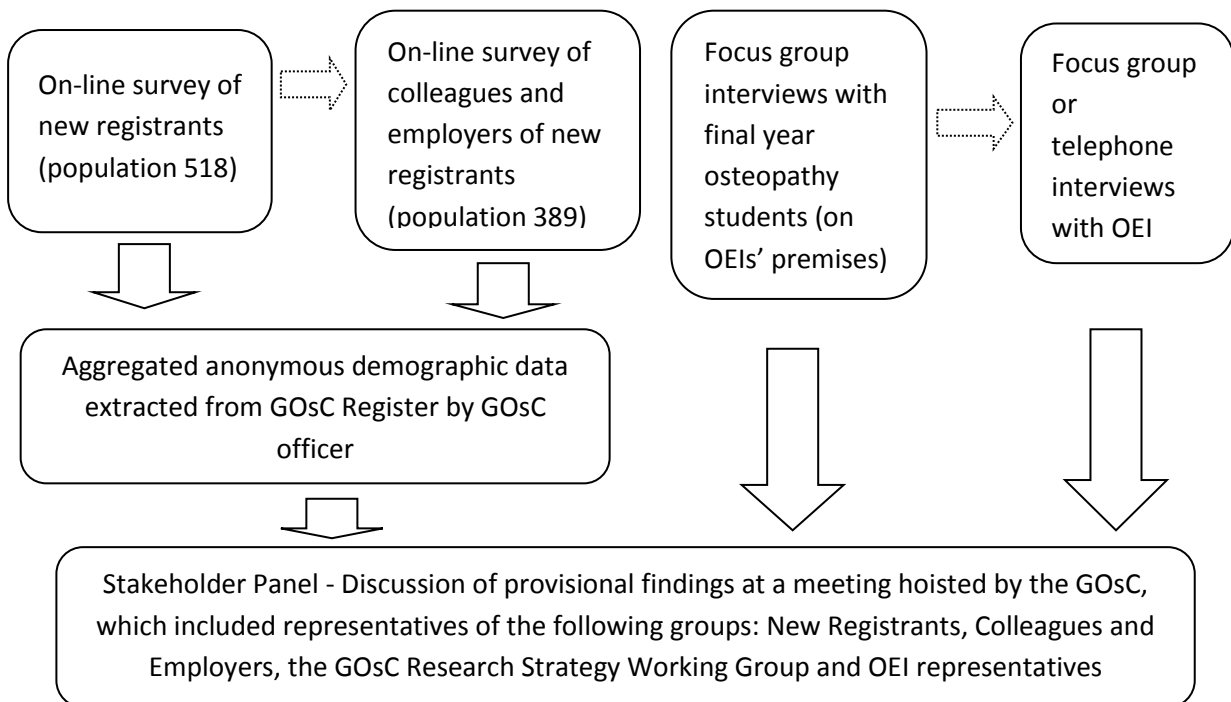


Figure 1: Main data collection activities

The use of on-line questionnaires was a cost-effective way to provide the whole population of New Registrants with the opportunity to participate in the study, irrespective of location; which when combined with appropriate reminders would be expected to achieve a similar response rate to a postal questionnaire.³ Similarly, using online questionnaires enabled the widest possible participation of Colleagues and Employers. Each questionnaire included a mixture of closed and open questions, eliciting quantitative and qualitative data. The quantitative data permitted exploration of some aggregate messages, while the qualitative

data was more diverse and could be set alongside interview and focus group responses. However, typed responses in text boxes should be expected to be less extensive, less nuanced and less elaborated than data arising from human interactions during the conversations that occur in individual interviews and focus group discussions. Consequently we offered telephone interviews to a purposively selected 10% sample of the New Registrant population (see section 2.2.1). Unfortunately, this strand of the study recruited too few participants to proceed (section 3.2.1), so it has been removed from

Figure 1.

OEI faculty and students naturally meet in groups in specific locations, offering the possibility of economical group-based qualitative data collection. Audio-recorded focus groups were selected as the main data collection method for these stakeholders because focus group discussions produce rich, qualitative data. Krueger and Casey⁴ suggest that focus groups are a valuable alternative to individual interviews in that, compared with individual interviews and many other forms of data collection, they have potential to become more participant led and less controlled by an interviewer. Shifting the focus to the participants rather than the interviewer, they suggest, uncovers more of the real world experience of participants. While discussion among participants is the principal advantage of focus groups, helping participants to explore and clarify their views; confident voices and popular views may dominate, making it difficult for quieter members to participate and for people to raise dissenting views.⁵ Skilful facilitation can substantially mitigate these difficulties. The researchers moderating focus groups during this study were experienced facilitators and tried to ensure that everyone was able to speak, but that cannot guarantee that all insights into osteopathy graduates' preparedness to practise were heard. Telephone interviews were offered for people who wanted to contribute to the study, but could not attend a focus group.

The prompts for focus group discussions and individual interviews were guided by the themes listed in section 2.3.1. An appreciative inquiry⁶ approach was used, focusing on positive aspects of learning. This supported further questions and discussion, and allowed exploration of topics raised by participants. At the end of each focus group participants were asked an 'in an ideal world' question to help them summarise their aspirations.

2.2 Identifying and encouraging potential study participants

2.2.1 New registrants

A GOsC officer interrogated the GOsC Register of Osteopaths to identify osteopaths who had first registered during 2009 or 2010 ('New Registrants') and sent invitations to participate in the study. Invitations were sent by email if an email address was available in the GOsC Register entry, otherwise by post (for a small minority). The invitations to participate were sent from the GOsC to preserve the confidentiality of data held on the GOsC Register. Each invitation contained a web link to the on-line questionnaire for New Registrants (Appendix 1a), from which anonymous responses could be submitted to the research team.

Demographic data was also extracted from the GOsC Register to facilitate non-respondent analyses (section 2.4.1) and the identification of a sample of 50 New Registrants (approximately 10%) that was representative in terms of geographical location and gender. New Registrants in the 10% sample were invited to contribute additional telephone interviews. As before, to preserve confidentiality the invitation to participate was sent by a GOsC officer. New Registrants with an interest in contributing to this aspect of the study were asked to contact a member of the research team by email, telephone or letter.

2.2.2 Colleagues and Employers

Having extracted the list of New Registrants, the GOsC officer interrogated the GOsC Register further, to identify experienced osteopaths (first registered before 2008) with the same practice address as one or more of the New Registrants. We termed this group of experienced osteopaths, 'Colleagues and Employers'. This process of identifying potential study participants was the best route that could be devised to link New Registrants with their experienced colleagues, but it was far from perfect. For example, the GOsC officer highlighted uncertainty about the completeness of practice addresses declared by osteopaths and time-lags before changes to practice addresses are reported to the GOsC. This may mean that the Colleagues and Employers group did not include all eligible experienced osteopaths.

Invitations to complete the anonymous online questionnaire for Colleagues and Employers were sent from the GOsC, as described in section 2.2.1.

2.2.3 Final year osteopathy students and OEI faculty

GOsC officers suggested key contacts at UK OEIs. Via these contacts, a member of the research team arranged separate focus group interviews with final year students and OEI faculty; or, where more practical, individual telephone or email interviews. For faculty

interviews we expressed a particular interest in including clinic tutors and course leaders with an overview of the curriculum.

2.2.4 Encouraging participation

To encourage participation in the study, it was well advertised and explained, data collection required only a small amount of time from participants and reminders were sent to potential participants. To advertise and explain the study, presentations were made during meetings of relevant groups hosted by the GoSC, such as research, education and communications groups: a summary information sheet was also distributed. The study was advertised through short items in *The Osteopath* magazine and the Chair of Council wrote to the Heads of OEIs to introduce the study and lend it his support. New Registrants and their Colleagues and Employers were sent study details and reminders directly to the email address they registered with the GOsC (and, where absent or undeliverable, by post).

Questionnaire length, interest in the questionnaire content (salience) and receipt of reminders are all important influences on questionnaire response rates.^{3,7-9} The online questionnaires for New Registrants and their Colleagues and Employers were designed so that they could be completed in less than 30 minutes, although there was scope for people who wished to dedicate more time to expanded answers to express detailed views in expanding text boxes. The style of questions varied throughout the questionnaire to help maintain interest and the multifaceted topic of New Registrants' preparedness to practise was expected to be salient for the targeted stakeholder groups. As recommended by Barclay and colleagues,⁹ three reminders were sent during the four months for which each questionnaire survey remained open.

Focus group interviews were held at OEI premises to minimise participants' travel and time commitments. The focus groups lasted around forty five minutes so the time commitment for each participant was strictly limited. In some cases student participants were interviewed between clinic appointments, so would dip into and leave the groups as necessary. When potential focus group participants wished to contribute to the study but could not attend a focus group at their OEI, they were offered a telephone interview instead. Focus group discussions and interviews were semi-structured and conducted flexibly to accommodate participants' priorities.

The general invitations to participate, issued in meetings and through *The Osteopath*, generated interest from a small number of experienced osteopaths who did not meet the criteria for inclusion in the Colleagues and Employers group. These people were able to contribute to the study by offering interviews which helped the development of the online questionnaires and prompts for focus groups; by piloting the online questionnaires or by completing an online questionnaire which mirrored the Colleagues and Employers

questionnaire apart from the questions relating to New Registrants in the study's 2009 and 2010 cohorts (see Appendix 1b for Colleagues' and Employers' survey).

2.3 Development of the questionnaire and interview topics

Data collection topics reflected the commissioning brief for this study, opinions expressed during orientation interviews with experienced osteopaths and GOsC officers, and literature from a range of health professions. The experienced osteopaths had identified themselves as interested in contributing, after becoming aware of the study from GOsC meetings or written communications. They did not fulfil the narrow criteria for inclusion in the study as 'New Registrants' or as 'Colleagues and Employers' (section 2.2.2), but did have insights into the transitions navigated by recently qualified osteopaths.

Health professions' literature on the topic of preparedness for practice (spanning research, opinion, guidance and regulation), indicated that new entrants' clinical skills and knowledge, interpersonal skills and professionalism are seen as fundamental (and sometimes troubling) aspects of preparedness to practise in every healthcare profession we examined. Consequently, these topics required examination in this study.

Since most healthcare professions' practitioners predominantly practise as salaried employees, at least in the early years of their careers, the health professions' literature does not examine entrepreneurial or business skills, and there is surprisingly little research about new graduates' business competence in non-health fields. However, an ongoing longitudinal study,¹⁰ tracking the progress of people who applied to university through UCAS in 2006 (any discipline, including health professions' students), has examined final year students perceptions of the skills they have to offer and the skills employers seek.¹¹ They found that final year students ranked 'entrepreneurial/ enterprise' skills bottom of eleven employment-related domains of expertise developed by their courses. This echoed the findings of a recent study by the Confederation of British Industry (CBI) and Universities UK (UUK),¹² which stressed the importance of developing successful university-employer partnerships and the responsibility of students to engage more fully in the processes of developing and articulating their employability skills. Most osteopaths are self-employed and New Registrants need sound business skills alongside clinical competence, well-developed interpersonal skills and professionalism. Therefore, perceptions of entrepreneurial and business skills development were elicited during this study.

Health professions' students need practice-based supervision, formative feedback and assessment. For osteopathy students, clinic tutors and experienced osteopaths in other practice settings fulfil this role. Turning to other professions, optometry and speech and language therapy, for example, are similar to osteopathy in making extensive use of university-run clinics, in addition to ensuring clinical experience in other settings. In nursing

and midwifery there are well-developed mentor-assessor roles which require a specific post-registration qualification.¹³ Medicine, on the other hand, has more variable and often lighter touch arrangements for mentorship and practice-based assessment of undergraduate students, who play a very limited role in the provision of care until they have passed their final degree examinations, including simulation-based OSCEs (objective structured clinical examinations). In this study, final year students and OEI faculty were asked about learning and assessment in clinical settings.

To support newly qualified practitioners transitions to practice, many health professions (using many different terms) have developed, to a greater or lesser extent, mentor roles and practice-based assessor roles. Several professions have structured programmes for newly qualified practitioners, such as preceptorship programmes lasting a few months for newly qualified nurses, midwives and allied health professionals,¹⁴ the two-year Foundation Programme¹⁵ for doctors and pre-registration periods of variable lengths for professions such as optometry and pharmacy^{16,17}. We will discuss these further in Chapter 10 (section 10.3). In contrast, mentorship of newly registered osteopaths is left to individual (often informal) arrangements and there is no structured programme for the early months of practice to support New Registrants' transitions to practice. There are no formal postgraduate assessments for New Registrants unless they choose to undertake additional postgraduate training relating to specific areas of practice. Nevertheless, many osteopaths participate in informal mentorship and New Registrants must comply with CPD requirements, at the latest ten months after joining the professional Register or within 14 months of graduation, whichever is sooner.¹⁸ Consequently, in this study New Registrants and experienced osteopaths were asked about mentorship and CPD.

2.3.1 Summary of data collection themes

In summary, the following themes were included in questionnaires and as interview or focus group prompts:

- **Clinical skills and knowledge**, including appropriate self-evaluation of competence (in relation to a wide variety of patients) and evaluation of the evidence-base for practice.
- **Interpersonal and communication skills** (with a wide variety of patients and in relation to situations presenting varying degrees of challenge; interaction with osteopathy colleagues and other healthcare professionals).
- **Entrepreneurial and business skills.**
- **Professionalism** (including, for example, recognising one's limited expertise and scope of practice, making appropriate referrals, valuing diversity, respecting confidentiality, commitment to patient safety and engaging in CPD).

- **Supporting osteopathy graduates' transitions into practice** (including mentorship and CPD).

2.3.2 Piloting questions

Questionnaires were piloted by a small group of osteopaths and minor amendments were made before they were launched on-line.

2.3.3 Making space for additional topics participants considered important

Focus group discussions and interviews were moderated flexibly to allow other important themes to emerge. Similarly, text boxes at intervals throughout the questionnaires encouraged the contribution of thoughts that could not be expressed within closed responses, such as Likert scales. These text boxes expanded to accommodate responses of any length.

2.4 Data analysis

2.4.1 Quantitative data

Summaries of quantitative data and non-respondent analyses were supported by SPSS v17. 'Non-respondent analyses' are important to examine the degree to which the study participants can be considered typical of all potential participants, but the potential for 'non-response bias' remains unexamined in most studies that survey health professionals.^{19,20} However, it should be noted that bias is not inevitable with low response rates and high response rates are not a guarantee of avoiding bias; what matters is the degree to which responders and non-responders characteristics or views differ systematically.⁹ For example studies of non-responder doctors working as General Practitioners (GPs) found that, compared with responders, they tended to be older, more experienced but less well qualified, more stressed and more likely to practise alone.^{9,21,22} This study compared demographic and work-related characteristics of survey respondents with anonymous summary data from the GOsC register, NHS workforce data and national population data (see sections 3.3 and 3.4). We also reflected on focus group participation (section 3.2.3). The Chi-squared (χ^2) goodness of fit test was used for variables with multiple categories and the binomial test for dichotomous variables.

Tables and graphs summarising quantitative questionnaire survey data appear Chapters 4-8, which reflect the data collection themes listed in section 2.3.1. Summaries of quantitative data are presented alongside qualitative data relating to the same themes.

2.4.2 Qualitative data

The focus group transcripts, interview transcripts and qualitative data from text boxes in the questionnaires were analysed together. This led to rich data from multiple perspectives, concerning the areas we had probed (see section 2.3.1). It also allowed the emergence of additional discourses, which will be reported in Chapter 9. A qualitative, inductive analysis was conducted through immersion in the data and thematic coding. Thematic analysis, as discussed by Joffe and Yardley,²³ is an extension to content analysis; going beyond categorising and counting to focus on meaning. The process was essentially as follows:

- Treating transcripts from focus groups and individual interviews, and free text responses on questionnaires, as a single data corpus containing multiple perspectives.
- Reading and re-reading to identify and code as many themes as possible. The whole corpus was coded by Paul McIntosh (PM), while Dawn Carnes (DC) independently coded a subset of transcripts. Independent coding was compared and discussed by all authors.
- Grouping codes into themes and testing the grouping - the grouping and testing processes were supported by: debate among the researchers, re-reading raw data to check the fit between proposed themes and groupings and each part of the data set; comparison with other research concerning new graduates' preparedness for practice; comparison with documents published by professional and regulatory bodies in healthcare, and feedback on provisional findings presented to the Stakeholder Panel meeting at the GOsC (see
 -
 -
- Figure 1 in section 2.1).
- The final part of the analysis involved distilling the meaning, dimensions and significance of themes.

Part II: Results and Findings

This Part of the report is divided into seven chapters, beginning at Chapter 3 with a summary of the research participants and analyses of the degree to which they can be considered typical; followed by Chapters 4-8, which predominantly reflect the data collection prompts listed in section 2.3.1 (see list below for individual chapter titles). Emergent themes are presented in Chapter 9.

Although Chapters 4-8 seek to examine different facets of osteopathy graduates' preparedness to practise, these things are intertwined and it is often difficult to consider one facet without including another. Competent clinical practice requires the seamless integration of clinical knowledge and clinical skills with well-developed interpersonal and communication skills, professionalism and sound business practices. Consequently, Chapter 4 expands beyond clinical skills and knowledge to include some more integrated views of New Registrants' clinical competencies, and comparisons of relative strengths and weaknesses in different areas of professional practice.

- Chapter 3 Review of research participants
- Chapter 4 Clinical skills, knowledge and competence
- Chapter 5 Interpersonal and communication skills
- Chapter 6 Entrepreneurial and business skills
- Chapter 7 Professionalism
- Chapter 8 Supporting osteopathy graduates' transitions into practice
- Chapter 9 Findings: Emergent and cross-cutting themes

The emergent themes that will be presented in Chapter 9 are 'Safe, if not always effective', 'Diversity, Variability and Uncertainty' and Autonomy and Isolation.

Chapter 3 Review of research participants

3.1 Key points

The New Registrants' questionnaire survey yielded 127 responses (response rate 24.5%).

- Non-respondent analyses showed that the questionnaire respondents can be considered representative of the population of New Registrants in respect of: gender, the OEIs at which they studied and the countries in which they were practising. However, respondents tended to be older than the wider population of GOsC New Registrants.
- Although the expected number of New Registrant survey respondents self-identified as White, significantly fewer respondents than expected identified themselves to be in a different ethnic group, while more than expected declined to identify their ethnicity.
- 81% of respondents were self-employed; 55% of respondents worked in group practices; 14% of respondents reported additional healthcare qualifications.

The Colleagues' and Employers' questionnaire survey yielded 61 responses (response rate 15.7%).

- Non-respondent analyses showed that the Colleagues' and Employers' Survey respondents were representative of the wider population of experienced osteopaths in respect of the geographical region in which they practised. However, experienced osteopaths working alongside graduates of the British School of Osteopathy were over-represented.
- Most experienced osteopaths responding to the Colleagues' and Employers' Survey reported that they worked alongside only one New Registrant.
- 72% of respondents were employers or lead practitioners in a group practice; 64% worked in practices with between two and four osteopaths.
- The median duration of practice for this survey's respondents lay in the interval 16-20 years, so most were very experienced osteopaths.

By definition, the Colleagues' and Employers' Survey focused on New Registrants who worked in group practices. It did not seek professional opinions about the preparedness of New Registrants who become 'single-handed' or 'lone' practitioners, although we received some comments about this group.

We do not know the degree to which focus group participants (final year students and OEI faculty) were purposefully selected by OEI key contacts, or simply a convenience sample.

3.2 Introduction

This chapter summarises key characteristics of the study participants and explores the degree to which the participants can be considered typical of the targeted stakeholder groups: New Registrants, their Colleagues and Employers, Final Year Osteopathy Students and OEI Faculty.

3.2.1 New Registrants

All New Registrants (518) were sent a link to an on-line questionnaire (Appendix 1a), which was open for four months from 18 April to 17 August 2011. Three reminders were sent during this period. Online responses were anonymous so reminders had to be sent to all New Registrants. The questionnaire addressed New Registrants' confidence in their clinical knowledge, clinical skills, evidence-based practice, interpersonal and communication skills, business skills; their participation in CPD and experiences of mentorship. It also elicited demographic data and views on various aspects of undergraduate preparation for osteopathic practice. Fifty purposively selected New Registrants (sampling details in section 2.2) were invited to contribute telephone interviews. The aim was to collect richer data than that which was anticipated from short written responses on questionnaires.

The New Registrants' questionnaire yielded 127 responses (response rate 24.5%). Seven respondents (5.5%) reported themselves ineligible for the survey in relation to both the year of first registration (not 2009 or 2010) and year of graduation (inclusion criterion: 2008-2010), while one questionnaire was blank. Thus eight responses were excluded from the analysis and 119 questionnaires were analysed. The degree to which survey respondents may be regarded as representative of all GOsC New Registrants is explored in section 3.3.

Only four New Registrants expressed an interest in contributing an interview, and three interviews were completed. The particularly low level of participation in this strand of the study was unexpected and disappointing, but this was mitigated by a relatively high incidence of expansive and thoughtful free-text responses within the online questionnaires, as will be demonstrated by quotations throughout this report. Transcripts from the three completed interviews were included in the corpus of qualitative data (see section 2.4.2).

3.2.2 Colleagues and Employers

Interrogation of the GOsC database identified 389 experienced osteopaths working at the same practice address as one or more of the New Registrants, termed 'Colleagues and Employers'. These experienced osteopaths were sent a link to an on-line questionnaire which was open for four months from 10th August to 9th December 2011. Three reminders were sent during this period. Again, the reminders could not be targeted to non-respondents, due to anonymous data collection. The Colleagues' and Employers'

questionnaire addressed similar areas to the New Registrants' questionnaire. It yielded 61 responses (response rate 15.7%). The profile of respondents and the degree to which they may be representative of the targeted population are explored in section 3.4.

A separate web link to a questionnaire that mirrored the Colleagues' and Employers' questionnaire was provided for any osteopath, wishing to contribute to the study, who was not a member of our Colleagues and Employers group. The link was advertised at meetings hosted by the GOsC and via *The Osteopath* magazine. This generated only one response, which was not added to the Employers' and Colleagues' data set for the inductive analysis, but later checked against that analysis to evaluate concordance.

3.2.3 Final year osteopathy students

Audio-recorded focus group discussions with final year osteopathy students were held at six of the eight UK OEIs from which New Registrants graduated (see section 10.5.1 for note on one non-participating OEI). These included 45 final year students. We cannot know how many students the OEI key contacts invited to participate in the focus groups or interviews, or the degree to which they were either purposively selected or a convenience sample.

3.2.4 OEI faculty

Sixteen faculty from six OEIs participated in face-to-face group interviews (14) or individual telephone interviews (2) - (see section 10.5.1 for note on one non-participating OEI). All interviews were audio-recorded. Although we expressed a particular interest in interviewing clinic tutors and also OEI faculty with roles that engendered an overview of the curriculum and graduates' early careers, for example course directors, we do not know which or how many faculty OEI contacts invited to contribute their views. Group interviews were dependent on the availability of faculty on the same day as the research fellow's visit to conduct a student focus group. Data analysis did not separate the views of clinic and non-clinic tutors, since some group interviews were mixed.

3.3 Profile of New Registrant survey respondents

3.3.1 Cohorts

Summaries of the 119 responses showed that respondents were evenly divided between 2009 registrants (59) and 2010 registrants (60) (see Table 1) and that 97% of respondents joined the GOsC Register in the year during which they completed their osteopathy degree.

		Year of graduation				Total
		2008	2009	2010	unknown	
Year of registration	2009	1	54	2	3	60
	2010	0	2	57	0	59
Total		1	56	59	3	119

Table 1: Cross-tabulation of dates of graduation and registration

3.3.2 OEIs

Responses were received from graduates of each of the OEIs (eight) that had graduating students in 2009 and 2010 (see Table 2, which also summarises GOSc Register data for the whole population of New Registrants). There was no significant difference between the distribution of survey respondents and the distribution of all the GOSc's New Registrants ($\chi^2 = 4.091$, 6 df, $p=0.664$): the survey respondents can be considered representative of New Registrants in respect of the OEIs at which they studied.

	Respondents (%)	GOSc Register (%)
British School of Osteopathy	37 (31.1)	176 (34.0)
European School of Osteopathy	16 (13.4)	79 (15.3)
College of Osteopaths	14 (11.8)	44 (8.5)
British College of Osteopathic Medicine	13 (10.9)	76 (14.7)
Surrey Institute of Osteopathic Medicine	11 (9.2)	39 (7.5)
Oxford Brookes University	10 (8.4)	55 (10.6)
London School of Osteopathy	8 (6.7)	40 (7.7)
London College of Osteopathic Medicine ^a	1 (0.8)	2 (<0.1)
Overseas ^a	1 (0.8)	7 (<0.1)
Missing ^a	8 (6.7)	0
Total	119	518^b

^a Rows removed from non-respondent analysis due to low expected frequencies. ^b The number of osteopathy graduates is likely to be higher, since not every graduate will register with the GOSc

Table 2: OEIs from which New Registrants graduated

3.3.3 Geographical distribution

Most respondents (105, 88%) were practising in the UK; six (5%) in other European countries and 2 (2%) outside Europe, (six unknown). This compares with 94% UK, 3% other European countries and 3% outside Europe for all GOSc New Registrants. Joining the non-UK categories to compensate for low expected values, allowed testing of the distribution of UK and non-UK practice: both χ^2 and binomial tests showed no statistically significant difference between respondents to this study and the population of GOSc New Registrants

($\chi^2 = 0.469$, 1 df, $p=0.493$; Binomial test $p=0.299$). Survey respondents had a similar national distribution to the wider population of New Registrants.

Unfortunately a question asking the UK region in which respondents practised was accidentally left out of the online survey so we cannot analyse responses by UK region. However the regional distribution of New Registrants was part of the anonymous data extraction from the GOsC Register and is shown in Table 27, Appendix 2.

3.3.4 Employment status

Respondents were asked whether they were sole traders, self-employed within a group practice, an associate practitioner employed in a group practice, or not currently practising. The results are shown in Table 3. This shows that 81% of respondents were self-employed (sole trader and self-employed categories), but 55% of respondents worked in group practices. However, when the stakeholder panel reviewed this distribution (see Figure 1 in section 2.1 of the methods chapter), panellists highlighted that some New Registrants have multiple employment arrangements so the distribution in Table 3 may not be as clear-cut as it appears. No comparison data exists for osteopaths' employment categories.

	Frequency (%)
Sole trader	49 (41.2)
Self employed in a group practice	47 (39.5)
An associate practitioner employed in a group practice	18 (15.1)
Not currently practising	1 (0.8)
Missing	4 (3.4)
Total	119

Table 3: Employment status

Table 3 also shows that just over half the respondents (55%) were working within group practices, increasing the likelihood of interaction with more experienced colleagues and opportunities for informal or formal mentorship: but by no means guaranteeing these interactions. A weak comparison can be made between the data in Table 3 and the anonymous data extracted to identify experienced 'Colleagues and Employers' of New Registrants (see section 2.2.2). The latter found that only 163 New Registrants (31%, see Table 28 in Appendix 2) shared their practice address with experienced osteopaths. However this comparison is an under-estimate because it overlooks New Registrants working alongside other recently qualified osteopaths (less than three years of registration). Furthermore, concerns that the study may not have been able to identify all experienced colleagues (section 2.2.2) add to the potential for the estimate based on GOsC Register records to be an under-estimate.

In view of the possibility that the results in Table 3 are an over-simplification, we have not compared the characteristics of those who work in group practices with those who identify themselves as sole traders.

3.3.5 Gender

Just over half the respondents were female (52%, see Table 4), compared with 56% of all New Registrants. The proportions of women in the two groups were not significantly different (Binomial test $p=0.377$) so the gender distribution of questionnaire respondents may be considered representative of GOsC New Registrants.

	Respondents (%)	GOsC Register (%)
Female	62 (52.1)	294 (56.8)
Male	51 (42.9)	224 (43.2)
Missing	6 (5.0)	0
Total	119	518

Table 4: Gender profile

3.3.6 Age

The age distributions of survey respondents and all New Registrants are shown in Table 5. The median age for New Registrants (GOsC Register) lay in the 20-34 band, while the median age for survey respondents lay on the 35-49 band. Testing the proportions of osteopaths under 35, and 35 or over, revealed a significant difference between the survey respondents and the wider population of New Registrants (Binomial test $p=0.034$): on average, survey respondents were older than the wider population of GOsC New Registrants.

Age (years)	GOsC (%)	Respondents (%)
20-34	299 (57.7)	54 (45.4)
35-49	203 (39.2)	52 (43.6)
50-65	16 (3.1)	5 (4.2)
66-above	0	0
rather not say		3 (2.5)
missing		5 (4.2)
Total	518	119

Table 5: Age profile of New Registrants and survey respondents

3.3.7 Ethnic background

The ethnic background of respondents is shown in Table 6; most were White British (63%). Only 20% of GOsC Register records identified ethnic background, preventing a meaningful

comparison with the ethnic backgrounds of this study's respondents. Instead a comparison was made with NHS non-medical workforce data,²⁴ although this required the use of more aggregated ethnic categories. While the percentage of respondents self-identifying as White in this study and the NHS Non-Medical Workforce Census was almost identical, a significantly higher proportion of respondents in this study did not identify their ethnicity (chi-squared test of proportions, $\chi^2=15.9$, 2df, $p<0.001$; see Table 29 in Appendix 2 for observed and expected frequencies).

Ethnic background of	Respondents	Respondents in aggregated categories	NHS non-medical staff^a
	Frequency (%)	Frequency (%)	Frequency (%)
White:		97 (81.5)	913,815 (82.4)
British	75 (63.0)		
Irish	4 (3.4)		
Other White background	18 (15.1)		
Mixed backgrounds:		1 (0.8)	11,469 (1.0)
White and Black African	1 (0.8)		
White and Black Caribbean	0		
Other mixed background	0		
Asian:		3 (2.5)	59,727 (5.4)
Asian British	2 (1.7)		
Pakistani	1 (0.8)		
Indian	0		
Bangladeshi	0		
Other Asian background	0		
Black		2 (1.7)	56,248 (5.1)
Black Caribbean	1 (0.8)		
Black African	1 (0.8)		
Black British	0		
Other black background	0		
Chinese	2 (1.7)	2 (1.7)	4105(<0.1)
Other	1 (0.8)	1 (0.8)	17,160 (1.5)
Prefer not to say	2 (1.7)	2 (1.7)	
Missing	11 (9.2)	11 (9.2)	46,671 (4.2)
Total	119	119	1,109,195

^a Source: Table 5.1 from The NHS Information Centre for health and social care 2010 Non-Medical Workforce Census. The NHS Information Centre (2011). Available from <http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-faculty-numbers/nhs-faculty-2000--2010-non-medical> retrieved 19.10.11

Table 6: Ethnic background

3.3.8 Other healthcare qualifications

A minority of respondents (17, 14%) reported additional healthcare qualifications. These included acupuncture, medicine, naturopathy, nursing, a pharmacy technician and physiotherapy; in addition to sports therapy, personal training and various types of massage therapy. Three others (2.5%) had healthcare-related degrees but did not declare healthcare qualifications (*viz*: physiology, psychology and rehabilitation studies).

3.4 Profile of Colleagues' and Employers' survey respondents

Sixty one experienced osteopaths completed the Colleagues' and Employers' survey. They had the following profile:

3.4.1 Professional position

Most respondents (72%) were employers or lead practitioners in a group practice (see Table 7).

	Frequency (%)
An employer/lead practitioner in a group practice	44 (72.1)
Self employed in a group practice	15 (24.6)
An associate practitioner/colleague employed in a group practice	2 (3.3)
Total	61

Table 7: Professional roles of experienced osteopaths

3.4.2 Years of practice as an osteopath

The experienced osteopaths who completed the Colleagues' and Employers questionnaire had widely differing lengths of service as practising osteopaths (Table 8), but the modal group was 21-25 years: they were very experienced osteopaths. The median duration of service lay in the interval 16-20 years (inter-quartile range between the intervals 6-10 years and 21-25 years).

Years	Frequency (%)
under 5	7 (11.5)
6-10	11 (18.0)
11-15	10 (16.4)
16-20	8 (13.1)
21-25	15 (24.6)
26-30	1 (1.6)
more than 30	9 (15.0)
Total	61

Table 8: Length of service of experienced osteopaths

3.4.3 Practice size

Most respondents (64%) worked in practices with between two and four osteopaths (Table 9). There is no comparison data for the size of osteopathic practices.

Number of osteopaths working in practice	Frequency (%)
1 ^a	1 (1.6)
2	20 (32.8)
3	9 (14.8)
4	10 (16.4)
5	6 (9.8)
6	6 (9.8)
7 or more ^b	8 (13.1)
missing	2 (3.4)
Total	518

^a Anomaly: there should be at least two osteopaths in each practice, the respondent & a New Registrant.

^b Range 7-11

Table 9: Responses to question ‘How many osteopaths work within your practice?’

3.4.4 Regional distribution

The survey respondents were concentrated in London and the South East (39%), with none practising in Wales (see Table 10).

	Frequency (%)
London	12 (19.7)
South East England	12 (19.7)
South West England	7 (11.5)
East Midlands	6 (9.8)
North East England	5 (8.2)
Scotland	5 (8.2)
West Midlands	4 (6.6)
East England	3 (4.9)
North West England	3 (4.9)
Southern England	2 (3.3)
Overseas	2 (3.3)
Wales	0
Northern Ireland	Not applicable
Isle of Man	Not applicable
Total	61

Table 10: Regional distribution of Colleagues' and Employers' Survey respondents

Although four New Registrants practised in Northern Ireland or the Isle of Man, no experienced osteopaths shared their practice addresses so the views of Colleagues and Employers could not be sought in these regions. After grouping some regions to reduce the number of cells with expected frequencies below 5 (see Table 30, Appendix 2), we found no significant difference between the regional distribution of survey respondents and the regional distribution of all those invited to complete the questionnaire (chi-squared test of proportions, $\chi^2=4.951$, 5df, $p=0.422$).

3.4.5 Details of New Registrants

The Colleagues' and Employers' Survey respondents generally worked alongside just one New Registrant (54, 89%), which is consistent with the generally small practice sizes reported in section 3.4.3. Half (30, 49%) worked alongside 2009 New Registrants and 39% worked alongside New Registrants from 2010. The remainder reported other years or were uncertain.

Respondents' reports of where their New Registrant colleagues had trained were as shown in Table 11, which includes each UK OEI with graduating students in the relevant years. Graduates from the British School of Osteopathy are over-represented in comparison with the population of GOsC New Registrants (Table 31, , Appendix 2; chi-squared test of proportions, $\chi^2=17.457$, 6 df, $p=0.008$).

	Frequency (%)	GOsC (%)
British School of Osteopathy	37 (55.2)	176 (34.0)
European School of Osteopathy	10 (14.9)	79 (15.3)
British College of Osteopathic Medicine	6 (9.0)	76 (14.7)
College of Osteopaths	4 (6.0)	44 (8.5)
Oxford Brookes University	3 (4.5)	55 (10.6)
London School of Osteopathy	2 (3.0)	40 (7.7)
Surrey Institute of Osteopathic Medicine	2 (3.0)	39 (7.5)
London College of Osteopathic Medicine	1 (1.5)	2 (<0.1)
Missing	2 (3.0)	0
Total (exceeds 61 due to some respondents working alongside multiple New Registrants)	67	518

Table 11: Colleagues' and Employers' reports of where their New Registrant colleagues trained

3.5 Summary

This chapter reported the number of study participants in the targeted stakeholder groups: New Registrants, experienced osteopaths working at the same practice addresses as the

New Registrants (termed Colleagues and Employers), final year osteopathy students and OEI faculty (particularly course directors and other roles with an overview of the curriculum, and clinic tutors). It also explored the profile of study participants with respect to several demographic and role related characteristics, for example: gender, age, and ethnic background; other healthcare qualifications; geographical distribution; when New Registrants qualified and when they joined the GOSc Register; which OEI they attended; the incidence of self-employment and of working in group practices. Non-respondent analyses were conducted to examine the extent to which survey respondents can be considered representative of the wider populations of New Registrants and their Colleagues and Employers.

In general, New Registrant respondents were typical of the population of GOSc New Registrants, with respect to the characteristics for which comparisons could be made (see Key Points in section 3.1). However, they tended to be a little older. In the absence of GOSc comparison data, ethnic backgrounds were compared with summary data from the NHS non-medical workforce census.²⁴ The proportion of White respondents in each study was almost identical, however significantly more New Registrants in this study declined to identify their ethnicity. The incidence of self-employment was high (81%). Fourteen percent of respondents reported additional healthcare qualifications.

Just over half (55%) of New Registrants worked in group practices. Group practices were generally small: a third of experienced osteopaths responding to the Colleagues' and Employers' Survey worked in group practices of just two osteopaths (Table 9).

The geographical distribution of Colleagues' and Employers' Survey respondents was representative of the wider population of experienced osteopaths. Most were very experienced osteopaths (median duration of practice in the interval 16-20 years). However, experienced osteopaths working alongside graduates of the British School of Osteopathy were over-represented.

By definition, respondents to the Colleagues' and Employers' Survey gave their professional opinions about New Registrants who worked in group practices, so this part of the study yielded no professional opinions about the preparedness of New Registrants who are single-handed practitioners.

Chapter 4 Clinical skills, knowledge and competence

4.1 Précis

Clinical competence requires the integration of many separate competencies. While this chapter largely focuses on clinical skills and knowledge, links are made to other facets of professional practice which will be discussed in subsequent chapters: interpersonal and communication skills (Chapter 5), entrepreneurial and business skills (Chapter 6) and professionalism (Chapter 7). We will see that the summary perceptions of the stakeholders consulted during this study, regarding New Registrants' preparedness to practise, could be synthesised as:

- Good underpinning knowledge
- Competence in a restricted range of clinical techniques.
- Sufficiently well prepared to commence clinical practice, in the expectation that they will continue to learn and broaden their experience.
- A substantial need for support in the early months.
- Safe, but not necessarily effective.
- Poorly developed business skills and unrealistic expectations.

Many experienced osteopaths enjoyed working with New Registrants, who were regarded as possessing important knowledge, skills and enthusiasms; whilst also needing support and mentorship. Some respondents described 'expansive' learning environments in which the whole practice learnt as a result of the presence of a New Registrant. However, some stressed that New Registrants' needed to be self-sufficient because colleagues lack the capacity to provide support.

Exploration of a 61% to 39% division between Colleagues and Employers who considered that New Registrants were sufficiently (51%) or well-prepared (10%) to practise, and those who doubted their preparedness, found:

- Among doubters, the main clinical strengths of New Registrants were perceived to be: safety and caution, taking thorough case histories, 'basics' of diagnosis and treatment, record-keeping, understanding of consent and ethical compliance. Their underpinning clinical knowledge was also noted.
- On the other hand, those who thought that New Registrants were sufficiently or well prepared for clinical practice were complimentary about New Registrants' theoretical and practical knowledge. As before, perceived clinical strengths included: safety, thorough case histories, record keeping, understanding of consent and ethical compliance; moving beyond these to include praise for diagnostic skills

and positive evaluations of a range of treatment techniques, while noting the range was limited. Other competencies and characteristics that were noted included: developing care plans; professionalism; developing competence in clinical reasoning, holistic thinking and osteopathic thinking; confidence and enthusiasm.

- Among those who doubted New Registrants' preparedness to practise, many areas of clinical practice were thought to need improvement, most often: discerning and communicating a prognosis; applying clinical knowledge; greater breadth of clinical knowledge and expertise; use of osteopathic principles and reasoning; critical thinking; being adequately selective in investigations and treatments; patient management; case histories; diagnosis; record-keeping; communication skills and maintaining patient dignity; building up speed; and business skills, particularly building and maintaining a patient base in private practice. Over-confidence and unrealistic expectations were also mentioned.
- Similarly, those who were satisfied with New Registrants' preparedness to practise listed: understanding prognoses; refining techniques and diagnosis skills; gaining experience of a wider range of conditions and patient groups, and particularly, more challenging cases; clinical reasoning and adopting a sufficiently selective approach; patient management; interpersonal skills; building up speed; business development. They also suggested refinements such as better appreciation of: the recovery process; complexity in patients' conditions and circumstances; when to seek advice; intra- and interprofessional communication. Consolidation, building confidence, patience and being realistic were also mentioned.

The overlap between the views of those who felt the preparedness of New Registrants was at least sufficient, and those who doubted this, indicated that they were underpinning their judgements by grading on broadly similar spectra of clinical and personal characteristics: the difference lies in calibration (which is likely to be influenced by respondents' dispositions and variation in the quality of New Registrants).

Final Year Students were looking forward to commencing professional practice, feeling they had sufficient knowledge and basic clinical skills to do this safely. They expected to 'learn from experience' and engage with CPD; thereby increasing their expertise and effectiveness. They seemed to have accepted a prevailing discourse that, initially, their practice would be 'safe, but not necessarily effective'.

OEI faculty reported that osteopathy degrees' emphasis on clinical education was intended to support *safe, autonomous* practice. In relation to statements about ways in which their degrees had prepared them for practice, New Registrants were generally positive. Combining agree and strongly agree responses, levels of support for statements about 'My degree ...' were:

- 74% '... provided me with the knowledge needed for osteopathic practice'

- 65% ‘... provided exposure to diverse clinical conditions’
- 65% ‘... provided sufficient supervised clinical practice’
- 64% ‘... taught me to evaluate my own competence’
- 61% ‘... taught me how to update my skills and knowledge’
- 60% ‘... provided exposure to a variety of client groups (e.g. babies, older people, ethnic diversity, disability)’

However, only 48% supported the statement ‘The assessments undertaken during my degree prepared me as well as possible for osteopathic practice.’

The most striking feature of New Registrants’ reports of the strengths and weaknesses in their clinical knowledge was its diversity: over sixty areas of confidence were named and over 100 areas of limited confidence were identified. Almost every area of confidence named by a New Registrant was also named by another as an area of limited confidence. The pattern for clinical skills was similar. This diversity was linked to variability and uncertainty experienced by Colleagues and Employers working alongside New Registrants. Diversity, variability and uncertainty also emerged in focus group discussions of clinical education and assessment.

4.2 Introduction

Although Chapters 4-8 focus on different facets of osteopathy graduates’ preparedness to practise: clinical skills and knowledge (Chapter 4); interpersonal and communication skills (Chapter 5); entrepreneurial and business skills (Chapter 6); professionalism (Chapter 7) and, finally, supporting osteopathy graduates’ transitions into practice (Chapter 8), these things are intertwined. It is often difficult to consider one facet of professional practice without including another. Therefore, this chapter begins with some global perceptions of osteopathic graduates’ preparedness to practise (section 4.3), followed by New Registrants’ evaluations of their degrees as preparation for practice (4.4) and their perceptions of relative strengths and weaknesses in different areas of professional practice (section 4.5). Section 4.6 is focused on clinical education and clinical assessments, drawing from focus group discussions with faculty and students. Study participants were also prompted to talk about evidence-based practice (EBP), which could be viewed as most closely aligned with the concerns of this chapter, ‘clinical knowledge, skills and competence’, or most closely aligned with ‘professionalism’ (Chapter 7). After inspecting the data, it made most sense to place perspectives on EBP in Chapter 7.

During this chapter we will see the emergence of three cross-cutting themes, to which we will return in Chapter 9: these are ‘Safe, but not always effective’, ‘Diversity, Variability and Uncertainty’, ‘Autonomy and Isolation’.

4.3 Summary perceptions of New Registrants' preparedness to practise

This section presents overall perceptions of New Registrants' preparedness to practise, among Colleagues and Employers (section 4.3.1), final year students (section 4.3.2) and OEI faculty (section 4.3.3). We will see that the summary perceptions of these stakeholders could be synthesised as follows:

- Good underpinning knowledge and competence in a restricted range of clinical techniques.
- Sufficiently well prepared to commence clinical practice, in the expectation that they will continue to learn and develop.
- A substantial need for support in the early months.
- Safe, but not necessarily effective.
- Poorly developed business skills and unrealistic expectations.

The emergent theme of 'safe, but not necessarily effective' will be explored further in Chapter 9, while business skills will be the focus of Chapter 6.

New Registrants were not asked to provide a global rating of their preparedness to practise, but the detailed responses made by New Registrants' in relation to many different aspects of practice will be reported in the following sections and chapters. We will see that their perceptions mirror the summary above.

Section 4.3.1 also describes variation in experienced osteopaths' enthusiasm for working alongside New Registrants.

4.3.1 Colleagues' and Employers' summary perceptions of preparedness

Respondents to the Colleagues and Employers Survey (appendix 1b), who were mainly very experienced osteopaths (section 3.4.2), provided a summary rating of how well they felt New Registrants were prepared for clinical practice. Three response categories were provided and all respondents completed the rating. The results are shown in Table 12. Half the experienced osteopaths (51%) thought New Registrants were sufficiently prepared for clinical practice and 10% thought they were very well prepared. Further exploration of the 61% to 39% division between Colleagues and Employers who considered that New Registrants were at least sufficiently well prepared, and those who doubted the preparedness of New Registrants, follows in section 4.5.2, where we will see that both groups described New Registrants as possessing a substantial knowledge base; being thorough and cautious, and consequently safe when undertaking the 'basics' of diagnosis and treatment.

'How well do you feel new registrants are prepared overall for clinical practice?' ...	Frequency (%)
very well	6 (9.8)
sufficiently prepared	31 (50.8)
not well enough	24 (39.3)
Total	61

Table 12: Colleagues' and Employers' summary perceptions of New Registrants' preparedness to practise

It was clear that many Colleagues and Employers regarded New Registrants as possessing important knowledge, skills and enthusiasms; sufficient to begin practice, but in need of additional support, a period of consolidation and refining practice, and opportunities to broaden their experience during the long process of building a patient base. Their comments about consolidation, refinement and development included those in Figure 2. The objective was seen as development towards better, more critical, clinical reasoning and more holistic osteopathic care.

- *"To consolidate clinical skills with further experience" (C/E)*
- *"Just refining technical skills and learning to deal with different patients attitudes towards health, expectations, demands placed on the practitioner to get them better. More people management" (C/E)*
- *"those which come with experience, such as, how long does it take for good improvement with treatment; what treatment works for which patient" (C/E)*
- *"practical work, how to address patients, how to maintain their patient base, working in a clinic environment (this is very different to a college clinic.)" (C/E)*
- *"Skill and experience. Patience of slow painful process of building up a Patient base." (C/E)*
- *"Understanding patient needs, explanation of treatment plan that the patient understands, ongoing development of treatment plans" (C/E)*
- *"having the confidence to carry out only the treatment that is necessary, rather than applying as many treatments as possible to a problem" (C/E)*
- *Confidence in patient management (including integration of osteopathic concepts into treatment of patients, prognosis; being adequately selective of treatment approaches) (C/E)*
- *"Realising all patients are different and don't conform to a uniform model (clinical maturity and experiential learning in a clinical setting.)" (C/E)*

Figure 2: Colleagues' and Employers' comments about New Registrants' development needs related to consolidation and refinement

Many experienced osteopaths enjoyed working with New Registrants. Some experienced osteopaths made comments that indicated the presence of 'expansive' learning environments.^{25,26} These are environments where new practitioners are not simply required to fit in and learn about how things are done, drawing from the expertise of more experienced colleagues (however supportive), but the newcomers are also recognised as

bringing new knowledge and ideas from which colleagues can benefit and through which workplace practices can evolve: the learning of the whole workplace expands. The two comments below illustrate this phenomenon:

- *"I love working with new grads they make me up my game! They know everything and haven't become stuck in their ways!" (C/E)*
- *"Taking on new graduates has been an invaluable learning curve for this large practice and myself" (C/E)*

On the other hand some experienced osteopaths preferred New Registrant colleagues to have very few support needs, in essence to be 'oven ready and self-basting',²⁷ or simply found that the support needs of less skilled New Registrants' exceeded their capacity to provide support. The two comments below illustrate this:

- *"Students are very variable. The best self educate or came into training with a good skill set. These often have been snapped up by their clinic tutors or wish to work for themselves. Weak graduates, however, are frankly not good enough. More than once I have felt like sending a graduate back to the graduating institution as "unfit for purpose". As an example, a student at interview could grasp fully the significance of P values but did not know which body system controls vasomotor, an osteopathic non-optional piece of knowledge. We no longer employ new graduates, they require too much training and support and are loss making." (C/E)*
- *"If their education is adequate, they shouldn't need support. If they need support, how can they graduate? Also, no practice can afford to carry a weak graduate; things are often marginal as it is." (C/E)*

Others framed their summary perceptions of New Registrants preparedness to practise in terms of osteopathy as a distinct practice. Lack of integration and excessive caution, linked to over-investigation or over-treatment, were common concerns. The first two quotations in the group below provide examples of these concerns. However, as will be a theme throughout this report, opinions varied and some respondents were very positive about New Registrants preparedness for the practice of osteopathy, as the fourth quotation illustrates:

- *"Overall I feel that pre-qualifying courses place too much emphasis on the research and dissertation elements of the course(s) at the expense of integrating manual and clinical skills with osteopathic concepts - the features about osteopathy which make it subtly unique". (C/E)*
- *"There is a tendency for new registrants to lack the confidence to carry out a focussed osteopathic process that leads from observation and case history, combined with clinical examination and palpation, to a strongly directed treatment plan. Most*

new registrant treatment plans tend towards over-treatment in an attempt to make sure everything has been attended to, when in fact there needs to be more distillation in this process". (C/E)

- *"Their patient management is poor due to being crippled by anxieties" (C/E)*
- *"Good knowledge of osteopathic principals, very positive and dedicated towards osteopathy" (C/E)*

4.3.2 Final year students' summary perceptions of preparedness

Focus group discussions with final year students revealed that, as they approached graduation, their summary perceptions about preparedness to practise were that they were ready to work with patients, but still had a great deal to learn. They considered that they possessed a substantial knowledge base and had become competent in key diagnostic and treatment processes, but anticipated extending their expertise through daily practice and, right from the beginning of their careers, through CPD. The focus group extract reproduced in Figure 3 illustrates this.

PAR1 *I feel ready to deal with patients absolutely. I think the diagnosis side is incredibly important, so that's what we're ready for. As far as specific techniques for dealing with specific conditions I don't think that's necessarily ... the grounding is there, but what I'm looking forward to most about leaving, that's the CPD stuff, so going on and actually ... going to specific regimes for specific problems so you can actually start developing specifically!*

PAR2: *By no means do I feel like my learning is done and I know everything that I need to know. I think we know enough to be safe, we know enough to know when something is wrong. We may not know exactly what it is but we're like, 'That's not right, that's not normal, that's a bit serious.' Um, so you know when you need to refer, to look up, um, so it's not like okay, we've passed our exams, we know everything we need to know, because there's so much we don't know. We have a basic grasp of, or more than a basic grasp of, um, what we can deal with and what we can't. I think, you know, I've heard the phrase used that we leave here a safe osteopath, not necessarily an effective osteopath, and it's like we know what we can and can't do, which I think is essential.*

PAR4: *And knowledge builds with experience so all the techniques, the hands-on, as with the CPD, it kind of gives us a different insight and different way to approach that patient.*

Figure 3: Extract from focus group with final year students

As to their threshold level of competence, students appeared to have learnt that the osteopathy curriculum was focused on ensuring their practice would be safe, even if not always effective. This was voiced, for example, in the contribution of participant 2 in the extract in Figure 3, who names a fundamental understanding of safety as knowing 'what we

can and can't do'. The discourse of 'safe, if not always effective' was widespread and appeared to be accepted as an appropriate level of competence for New Registrants. In the extract in Figure 4, we see the focus group moderator (researcher) probing the idea of safety, which revealed another very common perception, centred on not missing pathologies or 'red flags' in order to avoid misdiagnosis and the consequences that might flow from that. More will be said about the meaning of safety and the emergent theme of 'safe, if not always effective' in Chapter 9.

MOD: Can I come back to the term safety? When you say, we're safe, what do you mean by that?

PAR1: Well, one, that we're not missing any sort of pathologies. Making sure that our medical knowledge is up to date, as far as that's concerned. Because people tend to come in with a musculoskeletal problem, what they think is musculoskeletal, but it might not necessarily be.

MOD: Right.

PAR1: And if we were to miss that, that could be catastrophic as a result.

Figure 4: Extract about safety, taken from a focus group with final year students

4.3.3 OEI faculty: summary perceptions of preparedness

Safety also lay at the heart of faculty perceptions of New Registrants' preparedness to practise. Indeed from all perspectives, the argument that osteopaths need to be clinically competent is irrefutable, and this directs educational provision towards clinical learning. This is important, not only because it ultimately impacts on patients' wellbeing, but because it influences perceptions of how OEI's are performing. However, some faculty highlighted that it was possible to reach a stage of over-emphasis on underpinning knowledge and clinical skills, at the expense of other types of learning. For example, faculty from one OEI felt that perhaps they had lost some of the values and principles of osteopathy amongst other pressing matters, such as theoretical knowledge (e.g. anatomy and physiology) and they were actively looking to re-engage with osteopathic values and principles.

The main argument made for such depth of clinical knowledge was for the future ability to practise independently, which links to the emergent theme of Autonomy and Isolation (Chapter 9). As one participant from a faculty focus group said:

"I think what this course does is to prepare students to enter autonomous clinical practice, that's the key thing. It trains them to the level where they can effectively and efficiently manage patients on their own. It gives them a very strong theoretical background but the clinical training that they receive is aimed very high to prepare for the challenges that one faces in private practice. So we pay particular attention on the clinical training." (Faculty)

This quotation also shows faculty ambition for graduate attributes to extend beyond safety to encompass effectiveness and efficiency. However, clinical safety was clearly a threshold for graduation and there was more ambivalence about effectiveness

4.4 New Registrants' perceptions of their degrees as preparation for practice

Although the New Registrants' Survey did not ask respondents to provide a summary rating of their preparedness to practise, they did respond to a series of questions about different ways in which their degrees had prepared them for practice. The results are shown in Table 13 and Figure 5. The most strongly supported statement concerned New Registrants' knowledge base: 74% agreed or strongly agreed their degree had provided the knowledge needed for osteopathic practice. Other statements about degree preparation were also well-supported, with levels of agree and strongly agree responses reaching 65% for exposure to diverse clinical conditions and providing sufficient supervised clinical practice; 64% for learning to evaluate one's own competence, 61% for learning how to update their skills and knowledge and 60% for exposure to a variety of client groups. The lowest ranked statement was, 'The assessments undertaken during my degree prepared me as well as possible for osteopathic practice', and even in this case 48% of respondents agreed or strongly agreed, while only 12% disagreed or strongly disagreed (clinical assessments, in particular, will be considered further in section 4.6.2). On the dimensions we explored, New Registrants were positive about their degrees. A small number made free text comments suggesting that their clinic learning experiences had been limited by a shortage of patients, but this was not widespread.

	My degree provided me with the knowledge needed for osteopathic practice.	My degree provided exposure to a variety of client groups (e.g. babies, older people, ethnic diversity, disability)	My degree provided exposure to diverse clinical conditions	My degree provided sufficient supervised clinical practice	The assessments undertaken during my degree prepared me as well as possible for osteopathic practice.	My degree taught me to evaluate my own competence.	My degree taught me how to update my skills and knowledge
strongly agree	24 (20.2)	26 (21.8)	18 (15.1)	20 (16.8)	12 (10.1)	22 (18.5)	15 (12.6)
agree	64 (53.8)	45 (37.8)	47 (39.5)	57 (47.9)	45 (37.8)	54 (45.4)	58 (48.7)
slightly agree	17 (14.3)	24 (20.2)	24 (20.2)	20 (16.8)	33 (27.7)	25 (21.0)	20 (16.8)
slightly disagree	5 (4.2)	10 (8.4)	21 (17.6)	12 (10.1)	13 (10.9)	3 (2.5)	10 (8.4)
disagree	4 (3.4)	10 (8.4)	7 (5.9)	5 (4.2)	10 (8.4)	10 (8.4)	10 (8.4)
strongly disagree	4 (3.4)	3 (2.5)	1 (0.8)	4 (3.4)	5 (4.2)	4 (3.4)	5 (4.2)
missing	1 (0.8)	1 (0.8)	1 (0.8)	1 (0.8)	1 (0.8)	1 (0.8)	1 (0.8)
Totals	119	119	119	119	119	119	119

Note: numbers in parentheses are percentages

Table 13: New Registrants' perceptions of their osteopathy degrees as preparation for practice

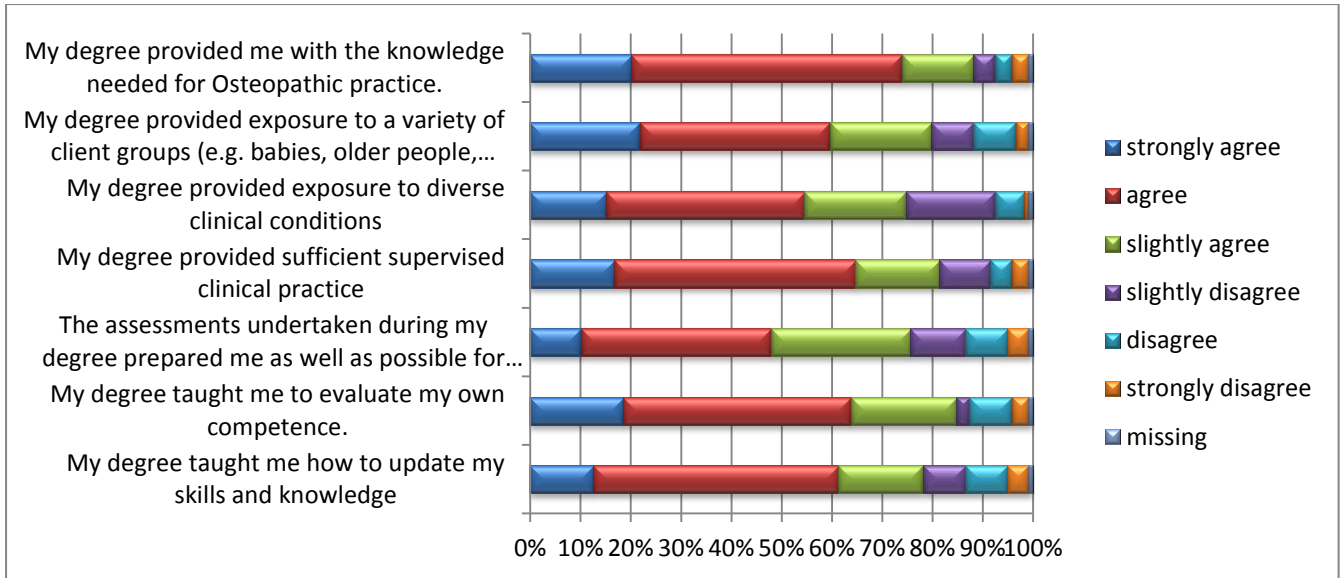


Figure 5: New Registrants’ perceptions of their osteopathy degree as preparation for practice

4.5 Strengths, weaknesses and diversity

Under the theme of strengths weaknesses and diversity, we first summarise New Registrants’ perceptions of their clinical strengths and weaknesses (section 4.5.1), then the views of Colleagues and Employers (section 4.5.2). The emergent theme of ‘safe, if not always effective’ appears again and we highlight another emergent theme, ‘Diversity, Variability and Uncertainty’, which will be explored further in Chapter 9.

4.5.1 New Registrants’ perceptions of their clinical skills and knowledge

Table 14 summarises, in descending order of frequency, the areas of clinical knowledge in which New Registrants reported the greatest and least confidence in their understanding and their ability to apply such knowledge; alongside the clinical skills for which New Registrants reported greatest and least confidence in their ability and understanding. Topics were included in Table 14 if at least 10% of respondents (12 or more) named that area of clinical knowledge or clinical skill, but in fact 66% of New Registrants reported anatomy as an area of confidence.

The most striking feature of New Registrants’ reports of the strengths and weaknesses in their clinical knowledge was its diversity: over sixty areas of confidence were named and over 100 areas of limited confidence were identified. Almost every area of confidence named by a New Registrant was also named by another as an area of limited confidence (including anatomy). The pattern for clinical skills was similar. The high level of diversity links to the emergent cross-cutting theme of Diversity, Variability and Uncertainty (Chapter 9), but in relation to clinical knowledge and skills it can be summarised as follows:

- Osteopaths' clinical knowledge is multifaceted and New Registrants have very diverse perceptions of their strengths and weaknesses.
- Osteopaths learn and apply a wide range of clinical skills and individuals vary widely in the strengths and weaknesses they identify within their own skills.

New Registrants have ...	Most confidence in ...	Least confidence in ...
Clinical knowledge	Anatomy Physiology or pathophysiology Differential diagnosis Musculoskeletal knowledge Neurology	Diagnosis Management (of a wide variety of issues) Treatment (various aspects) Pharmacology Specific patient groups (particularly children, pregnant or postpartum women, people with HIV and people with mental health issues)
Clinical skills	Several types of testing, particularly neurological testing Various osteopathic techniques Taking a case history Diagnosis Examination	Various osteopathic techniques, particularly high velocity thrusts Several types of testing

Table 14: New Registrants' perceptions of strengths and weaknesses in their clinical knowledge and skills

4.5.2 Colleagues and Employers perceptions of strengths and weaknesses

Respondents to the Colleagues' and Employers' Survey identified the comparative strengths and weaknesses of New Registrants in four different areas of professional practice, which will be considered separately in Chapters 4-6, underpinning theory (Chapter 4), clinical skills (Chapter 4), interpersonal and communication skills (Chapter 5) and business skills (Chapter 6). The results are displayed in Table 15 and Figure 6: over two fifths of the Colleagues and Employers group chose theoretical knowledge to underpin clinical practice as New Registrants' primary strength, while 36% chose clinical skills. Business skills were clearly identified as New Registrants' least developed expertise.

To interpret Table 15 and Figure 6 safely, it should be remembered that these are relative judgements. Selecting theoretical knowledge as the strongest element of New Registrants' expertise does not give any information about the perceived level of that expertise, which could be excellent or unsatisfactory. Similarly business skills are a relative weakness, but could still be considered satisfactory. However, over the following pages, when we triangulate the results in Table 15 with other data pertaining to New Registrants' expertise,

perceptions of levels of expertise will become clearer. We will see praise for New Registrants’ knowledge; a view that they have good clinical skills, but a limited range; but with respect to business skills, widespread concern that New Registrants do not properly appreciate how to build and maintain a successful osteopathy practice.

Colleagues and Employers think New Registrants are best and least good in the following areas ...	Best at ... Frequency (%)	Least good at ... Frequency (%)
Theory underpinning practice skills	26 (42.6)	1 (1.6)
Clinical Skills	22 (36.1)	11 (18.0)
Interpersonal and communication skills	9 (14.8)	12 (19.7)
Business skills	0	29 (47.5)
Other	4 (6.6)	8 (13.1)
Totals	61	61

Table 15: Colleagues and Employers perceptions of New Registrants' relative strengths and weaknesses

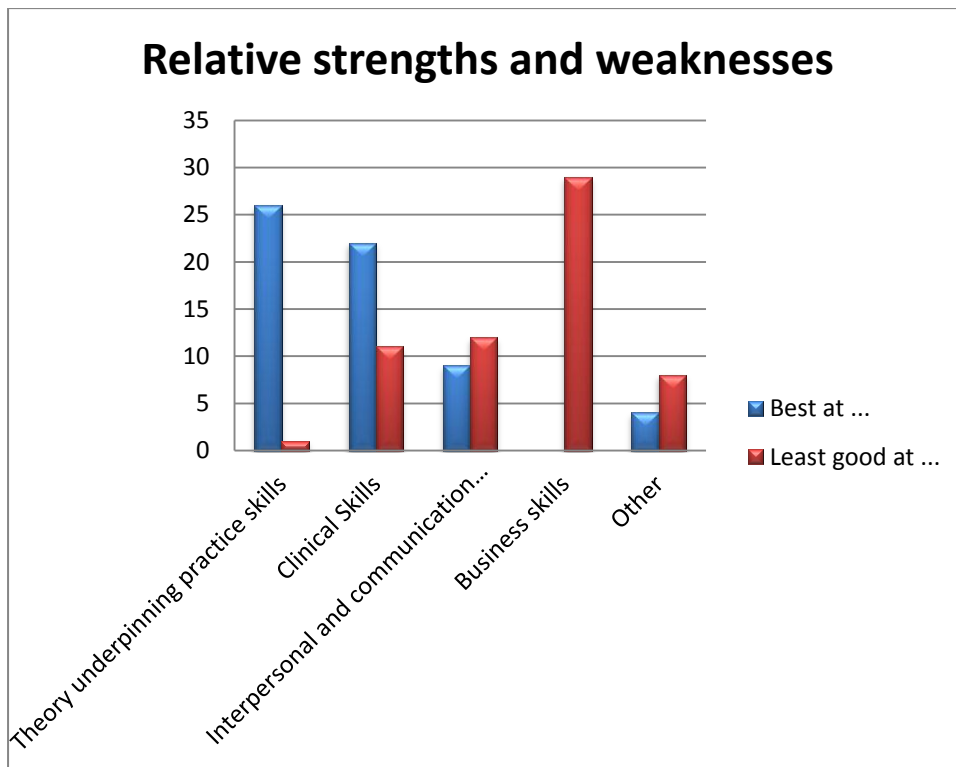


Figure 6: Comparisons of Colleagues' and Employers' perceptions of New Registrants' areas of expertise

Within this chapter we should to drill down into perceptions of clinical knowledge and clinical skills. Further exploration of the 61% to 39% division, reported in section 4.3.1, between Colleagues and Employers who considered that New Registrants were at least sufficiently well prepared to practise, and those who doubted the preparedness of New Registrants, found some differences in perceptions of clinical strengths and development needs. However, the emergent theme of ‘safe, if not always effective’, to which we will

return in Chapter 9, appeared in the responses of both doubters and those who were satisfied with New Registrants' preparedness to practise.

Among doubters the main clinical strengths of New Registrants were perceived to be: safety and caution, taking thorough case histories, 'basics' of diagnosis and treatment, record-keeping, understanding of consent and ethical compliance. Their underpinning clinical knowledge was also noted. On the other hand, those who thought that New Registrants were sufficiently or well prepared for clinical practice were complimentary about New Registrants' theoretical and practical knowledge. As before, perceived clinical strengths included: safety, thorough care histories, record keeping, understanding of consent and ethical compliance; moving beyond these to include praise for diagnostic skills and positive evaluations of a range of treatment techniques, while noting the range was limited. Other competencies and characteristics that were noted included: developing care plans; professionalism; developing competence in clinical reasoning, holistic thinking and osteopathic thinking; confidence and enthusiasm.

Turning from clinical knowledge to clinical practice: among those who doubted New Registrants' Preparedness to practise, the main areas of clinical practice which were thought to need improvement included: discerning and communicating a prognosis; applying clinical knowledge; increasing the breadth of clinical knowledge and expertise in respect of presenting conditions and appropriate advice and treatment; use of osteopathic principles and reasoning; critical thinking; being adequately selective in investigations and treatments; patient management; case histories; diagnosis; record-keeping; communication skills and maintaining patient dignity; building up speed; business skills, particularly building and maintaining a patient base and appreciating that private practice brings different demands to those experienced in OEIs' clinics. Unrealistic expectations were also mentioned. Similarly, those who were satisfied with New Registrants' preparedness to practise listed: understanding prognoses; refining techniques and diagnosis skills; gaining experience of a wider range of conditions and patient groups, and particularly, more challenging cases; clinical reasoning and adopting a sufficiently selective approach; patient management; interpersonal skills; building up speed and business development. They also suggested refinements such as better appreciation of: the recovery process; when to seek advice; intra- and interprofessional communication, and complexity in patients' conditions and circumstances. Consolidation, building confidence, patience and being realistic were also mentioned.

The overlap between the views of those who felt the preparedness of New Registrants is at least sufficient, and those who doubted this, indicated that they were underpinning their judgements by grading on broadly similar spectra of clinical and personal characteristics: the difference lies in calibration. This probably reflects both the variability of New Registrants and the varied hopes and expectations of the experienced osteopaths. The main areas for clinical development that respondents identified often included the same areas of

professional practice that others (and sometimes even they) had identified as strengths. This echoes the diversity of perceptions, linked to uncertainty, which we reported in New Registrants' responses (section 4.5.1). Several respondents drew attention to the diversity of New Registrants' strengths and weaknesses. In the quotation below, one respondent described a particularly proactive strategy for assessing and addressing New Registrants' strengths and weaknesses:

"They are all different. - That is why I read ALL notes written by new osteopaths in my clinic and spend 4 [unclear] a week working with them for the first 3 - 6 months. We identify areas that need work & I help them to develop." (C/E)

Diversity was not wholly limited to individual variation; some respondents felt New Registrants from different OEIs had slightly different skill profiles. We will return to this perception in section 7.3.3 and in our discussion of Diversity, Variability and Uncertainty in Chapter 9.

4.6 Clinical education and assessment (Faculty and students)

Focus group discussions with final year students and faculty focus group discussions often turned to the topic of clinical education and clinical assessments. Once again, diversity, variability and uncertainty were features of the data and we return to this in Chapter 9.

4.6.1 Clinical learning and learning environments

All OEIs offered some type of in-house clinic experience; on-site within the OEI or a community-based practice. Much of students' clinical practice learning occurred in these clinics where, under the supervision of clinic tutors, they saw patients who self-referred to the OEI clinic. The clinic tutors were mainly practising osteopaths, in private practice, with a part-time commitment to the OEI. There was noticeable variation between OEIs in the extent to which students participated in all aspects of running the in-house clinic, and in the clinic opportunities that each OEI could offer. Participation in non-clinical aspects of running the in-house clinic can help develop business skills and improve preparedness for practice (see Chapter 6).

Some osteopathic practices provided student placement opportunities, but participants in this study did not mention the contribution these make to preparedness to practise. However, this (on reflection, surprising) silence was not probed during data collection. Some students did not have placement opportunities in private osteopathic practices. One consequence of undertaking all clinical learning in an in-house clinic was that learners could be slightly cosseted and not see the reality of clinic practice, unless the in-house clinic was designed to replicate small business practices. Depth and variety of clinic experiences was seen by some as a benchmark of excellence.

Faculty and students described some highlights from the clinic experiences some OEIs' students could access, in-house and through links to local health and social care providers. The three quotations in Figure 7 illustrate highlights from the range of clinic opportunities that students may encounter, and a clinic for homeless people offered a further, unusual opportunity for extending the scope of students' clinical experience. The rationale for OEIs forging the inter-agency links that support these diverse opportunities for clinical learning was that students (and often tutors) would see pathologies that they would otherwise be unlikely to see through the normal flow of patients' self-referral to in-house clinics or private osteopathic practices.

Interestingly, in the focus group interviews, final year students and faculty did not speak of consolidation of clinical learning, begging the question whether this may be an underdeveloped or insufficiently emphasised aspect of their educational programmes.

- *“So the other aspect that gives me confidence to say that the individuals we are graduating are much more prepared compared to say 15 years ago is that we are quite fortunate to have a contract with [name] PCT which enables all the [name] GP practitioners [to refer] their patients here, and [the] sort of presentations ... that the guys are seeing in clinic be it under supervision is excellent. Sometimes it can take you about 5 years in practice before you see that.” (Faculty)*
- *“one of the HIV [clinics], they run out of the [name] Hospital and the students are working [with] multi-disciplinary teams, they're working with consultants, psychotherapists and as an undergraduate programme they're in this massive multidisciplinary team and seeing that work and the dynamics and the communication and you know I think the hidden part of that is a phenomenal experience for our students.” (Faculty)*
- *“We've got sports clinic, pregnancy clinic, HIV clinic, some of the institutions who I have spoken to haven't even thought of these concepts so that's really good, so we get exposed to lots of different patients groups. And yes we've got a clinic within a hospital so it is good to get that NHS experience as well.” (FYS)*

Figure 7: Highlights from clinic opportunities for students

4.6.2 Clinical assessments

Although students liked working in in-house clinics, they were sometimes critical of the formative feedback they received from clinic tutors, which they considered may affect their preparedness to practise or their performance in summative (graded and pass/fail) assessments. Some suggested that the common practice of session-based employment for clinic tutors made them anxious to leave at the end of clinic sessions, which tended to run over because students work slowly. Consequently formative assessment of clinic performance could sometimes be rushed, patchy, or delayed and possibly then forgotten. Students' also noted variability between clinic tutors' advice, which created uncertainty for the students, even though it may be perfectly reasonable for different professionals to hold

different professional opinions. Some students also suggested that the number and turn-over of clinic tutors offered little continuity in the evaluation of students' developing clinical practice, although one reason for having different clinic tutors was to use specialist expertise to support different types of clinical learning. The following quotation illustrates some of these aspects of the student data set:

"I think because time is so precious during clinic we're usually run over anyway, usually the last people to be in the building are the students way after their tutors have already left. So that window of opportunity to get feedback at the end of each clinic session is often missed because you're so busy. We do, we get feedback at the end of a term and quite often it does ... you get the sense of why didn't you tell me that sooner, because now, I'm not going to see this bunch of tutors again for potentially a year or never, so you can't follow that through. So it never gets picked up again by the next bunch of tutors and you never really get that smooth progression of feedback to 'let's help you develop now to try and combat that'."
(FYS)

Turning to summative assessments: Clinical progression was a common theme in the interview narratives. Gradually increasing levels of skill had to be deemed met in order to pass to the next level and this seemed to include areas such as abiding by clinic guidelines and professional standards, as well as osteopathic technique. In common with students studying any subject, students contributing to this study felt the variability of their expertise across the range of matters to be assessed and that assessment performance contained an element of luck. One focus group participant described this as follows:

"... it's potluck whether you get the one you're not very good at, or one that you're particularly competent at. That's not examined on that basis so I suppose there isn't perhaps a follow-up [action plan] or anything like that ..." (FYS)

In addition, two types of anxiety about summative clinical assessments were raised by both faculty and students. The first centred on whether there was some coaching which was designed simply to aid students to pass assessments (as opposed to more thoroughly develop clinical competence). Whilst it is one thing to give people the skills to pass a test, it would appear that the anxiety lies around learning being directed into passing it, at the expense of wider, deeper and more complex learning. This anxiety may partly illuminate why the statement 'The assessments undertaken during my degree prepared me as well as possible for osteopathic practice' was the lowest-ranked of seven statements concerning New Registrants' degrees (section 4.4).

The second anxiety centred on the inherent variations in patients and patients' conditions, some being easier to treat than others, which could result in some students' practice-based assessments being easier than those of other students. The logical repost to this would be that a sufficiently large number of practice-based assessments would average out such variation. However, this is another example of the prevalent discourse of Diversity,

Variability and Uncertainty, to which we will return in Chapter 9. A further example arose when students highlighted that clinical assessors had diverse approaches to their role, as illustrated by the focus group extract in Figure 8.

PAR2: *Some clinicians are different to others. Some will come into the room all the time while you're presenting to them throughout the whole year. Come and sit down, watch you question, watch you examine and watch you treat.*

MOD: *Yeah.*

PAR2: *Other clinicians are very much, you'll go away, you'll do the questioning, we'll come back out and present our questioning findings to them. We then go back in the examination, come back out, they'll just come into the room when we want to do the appropriate form of treatment".*

Figure 8: Student focus group extract about clinic-based assessment

Faculty provided additional support for students who failed clinical assessments. Some students felt there could be a fine line between passing and failing, causing disadvantage to those who passed by a narrow margin and consequently did not receive extra support. The focus group extract in Figure 9 illustrates this.

PAR3: *So I think, for me personally, you know, if you fail, you get support, but if you pass, then you don't, necessarily. It's not to the same level. And part of that, I know, is because it's a mature student course and they expect you, you know, if you need help, you'll go and ask. I know mature students, I know many who've been through this sort of thing before, but...*

MOD: *Are you saying, then, that potentially, just hypothetically, really, the difference between sort of maybe not passing and getting the extra support, and just passing and not getting the support, is something that might affect confidence in terms of when you qualify?*

PAR3: *Absolutely, yes.*

MOD: *Right.*

PAR3: *I think so. Because I think you need to build up your confidence as you go through the course, not hope that if you pass your final exam, that will give you the confidence to carry on. I think that maybe that is something that's lacking for the students in the middle who aren't really good or really bad.*

MOD: *Right.*

PAR3: *That there's almost a... They expect you to get through it. I don't know. I found that quite difficult, really.*

Figure 9: Student focus group extract about the impact of targeted support for failing students

OEI faculty reported that the emphasis within osteopathy degrees lies with clinical education which is intended to support *safe, independent* practice. Consequently, safety is the 'bottom line' for clinical assessments. We will return to safety in Chapter 9. The emphasis on independence arises because osteopathy is essentially a self-employed profession with a high proportion of lone practitioners (sections 3.3.4 and 3.4.3). Even when working in a group practice, there may be little interaction between the

(predominantly self-employed) practitioners who share the practice premises. The emphasis on independence also links to an emergent theme of Autonomy and Isolation, which will be reported in Chapter 9.

4.7 Summary

This chapter considered summary perceptions of New Registrants' preparedness to practise and drilled down into perceptions of preparedness in relation to specific aspects of clinical practice. Study participants (New Registrants, their colleagues and employers, final year osteopathy students and OEI faculty) regarded New Registrants' up to date knowledge as their most important asset. Their clinical skills were thought to be sufficiently well developed to support safe practice. Variability and uncertainty were evident across the data, from multiple perspectives. The early months of New Registrants' practice were described in ways that suggested a period of consolidation, refinement and expansion of clinical skills; resulting in more confident clinical practice which better integrated clinical skills and knowledge with other aspects of professional practice, such as holistic patient management and knowing when to seek input from others. Study participants' characterised New Registrants' initial practice as likely to be 'safe, if not always effective'. Effectiveness was seen to extend beyond technical clinical matters of osteopathic techniques, clinical skills and the application of appropriate clinical knowledge, to encompass discerning selection of tests and interventions alongside holistic patient management. Participants' main assumption appeared to be that refinement and expansion of expertise would flow from engagement in clinical practice.

One theme that was unexpectedly missing from faculty and student data sets was consolidation of clinical learning within OEI programmes. However New Registrants were positive about their degrees.

Although this chapter largely focused on clinical skills and knowledge, links were made to other facets of professional practice. For example, reporting Colleagues' and Employers' views of relative strengths and weaknesses highlighted perceptions of poorly developed business skills, to which we will return in Chapter 6. As a further example, we reported that some experienced osteopaths enjoyed working with and supporting New Registrants, while some found this undesirable or too great a burden. Supporting New Registrants' transitions into practice will be the focus of Chapter 8. OEI faculty reported that osteopathy degrees' emphasis on clinical education was intended to support *safe, independent* practice. This emphasis on independence links to an emergent theme of autonomy, which will be reported in Chapter 9.

Chapter 5 Interpersonal and communication skills

5.1 Précis

Interpersonal and communication skills underpin many of the clinical skills that were discussed in Chapter 4, for example:

- strengths in record-keeping and taking thorough case histories
- development needs for communicating a realistic prognosis; providing tailored, patient-centred advice; appreciating the role of interpersonal and communication skills in building and maintaining a patient base.

Colleagues' and Employers' evaluations of New Registrants' interpersonal and communication skills can be summarised as follows:

- Generally middle ranking: less well developed than clinical knowledge and skills but better developed than business skills.
- New Registrants were most skilled when working with patients and least skilled when working with other professionals (as opposed to their direct colleagues).
- Most (56%) felt New Registrants could explain treatments to patients in ways which were accessible and understandable
- Most (57%) were ambivalent about New Registrants' responses to patients' anxieties, frustrations and pain
- More (66%) were ambivalent about New Registrants' management of challenging situations and 20% suggested New Registrants cannot use interpersonal skills effectively in challenging situations.
- Poor interpersonal and communication skills could substantially reduce the chance of continued employment in group practices.

New Registrants' felt their osteopathy degrees had prepared them well for teamwork (81%), making appropriate referrals or relaying advice on future treatment (78%) and managing conflict (72%, substantially more positive than Colleagues' and Employers' reports of preparedness to manage challenging situations). While the majority (55%) also felt well-prepared for consulting other professionals, 39% felt they were not very well prepared for this aspect of practice.

Recurrent themes in New Registrants' examples of situations whilst working with patients or colleagues, when their interpersonal and communications skills had served them well included:

- Convincing, without over-alarming, patients who need to see a GP.
- Communicating with GPs.
- Explaining what osteopathy is and how it can help.

- Reassuring patients who are nervous of osteopathic treatments.
- Not shying away from strong emotions (but identified by some as an area for development).
- Remaining resolute when under pressure from patients (but identified by some as an area for development).
- Consulting more experienced osteopaths or other professionals when they felt close to the limits of their expertise.

New Registrants also indicated that, having initially been prone to over-optimism, they were developing ways of communicating more realistic assessments of what osteopathy might achieve, and how long and difficult the process might be.

In addition to the areas for development noted above, themes in New Registrants examples of situations in which they needed better interpersonal and communication skills included:

- Making suggestions to more experienced colleagues and resisting pressure from them.
- Persuading patients who are reluctant to see their GP again before treatment continues.
- Feeling “*upset and frazzled*” by complaints from patients (some of which were felt to be justified and some unjustified).
- Communicating with the parents of very young babies.
- Working with patients with communication difficulties.

Several New Registrants cited returning patients and patients referring friends as evidence to support self-evaluation of good interpersonal and communications skills. Equally, they interpreted non-returning patients as indicative of failures in interpersonal skills or communication. Some had previously pursued careers that helped develop strong interpersonal and communication skills.

Osteopathy degrees placed more emphasis on developing communication skills to aid diagnosis and other clinical procedures, rather than the development of interpersonal skills to support patient management. Most attention focused on pragmatic clinical matters, such as how best to elicit information whilst taking case histories, and formal communication between professionals, including legal processes. Humanism and the communication aspects of patient safety were more lightly touched upon. Curriculum elements included lectures and some more interactive classes delivered by OEI faculty and visiting speakers, such as psychologists and counsellors; but it was also expected that students would learn a great deal from the role modelling of clinic tutors. Overall, interpersonal and communication skills appeared to be a bolt-on addition to the clinical curriculum. Faculty identified this area of learning and teaching as under-developed, but struggled to envision improvements.

The narrative relating to clinic learning was typified by levels of uncertainty and the identification of variation: another manifestation of the emergent theme of Diversity, Variation and Uncertainty (Chapter 9). The uncertainty for students centred on the

development of interpersonal skills as being left to chance by observation of clinic tutors and more senior students. Another major issue was how to ensure consistent teaching in the context of: unpredictability surrounding the range of patients a student might meet in clinic, and variation in tutors' abilities to demonstrate and apply interpersonal and communication skills. Final year students felt academic and clinic teams assumed students would "*Learn by osmosis*" from observations and exposure to the clinic environment. The reality for students was of mixed experiences – from the very good to the awful.

Students expressed concerns about their preparedness to practise with respect to patients with support needs related to mental health or mental capacity. Some OEs had begun to explore ways to meet these learning needs, but, provision was patchy.

5.2 Introduction

We begin with Colleagues' and Employers' perceptions of New Registrants' interpersonal and communication skills in the workplace (section 5.3), since this provides a succinct third party summary of New Registrants' preparedness for this aspect of practice. Here, as in the other aspects of practice examined in Chapters 4-8, Colleagues and Employers are not disinterested third parties: they are experienced practitioners with professional reputations and businesses to protect. Consequently, they will be vigilant and sensitive to New Registrants' performance (in those parts of the workplace where performance can be observed). In section 5.4 we turn to New Registrants self-evaluations of their interpersonal and communications skills, and their perceptions of the preparation their osteopathy degrees provided for some facets of professional practice. Section 5.5 contains interwoven narratives from faculty and final year students.

5.3 Colleagues' and Employers' perceptions

In the previous chapter (section 4.3.1) we identified (in Table 15) that 15% of respondents to the Colleagues' and Employers' Survey selected interpersonal and communication skills as the best aspect of New Registrants' practice (less frequently selected than theoretical knowledge and clinical skills), while 20% selected interpersonal and communication skills as the weakest part of New Registrants' practice (although a much greater number selected business skills). For the majority of respondents (65%), this renders the development of interpersonal and communication skills as middle-ranking among other facets of practice. However, as in section 4.3.1, we must caution that these are relative judgements, not anchored to any level of a scale that might extend from excellent to unsatisfactory.

To add a little texture to this middle-ranking evaluation, colleagues and employers answered closed questions about the situations for which New Registrants' communication skills were most and least well developed: the results are presented in Table 16 and Figure

10: again, these are relative judgements, not anchored to any scale. The table and graph show that New Registrants were most skilled when working with patients and least skilled when working with other professionals (as opposed to their direct colleagues). In section 5.4 we will see that the emphasis within New Registrants self-evaluations was similar. Among other comments we received, was the suggestion that when New Registrants lacked clarity in their communication, this could be a symptom of a lack of clarity in their clinical reasoning or understanding: this point was also made in the New Registrants' data set (section 5.4).

Situations for which New Registrants' communication skills were most and least well developed ...	Best ...	Least developed
	Frequency (%)	Frequency (%)
When working with patients	26 (42.6)	16 (26.2)
When working with colleagues	20 (32.8)	8 (8.2)
When liaising with other professionals	2 (3.3)	29 (47.5)
other	8 (13.1)	0
Missing	5 (8.2)	8 (13.1)
Totals	61	61

Table 16: Colleagues' and Employers' relative judgements of New Registrants' communication skills in different situations

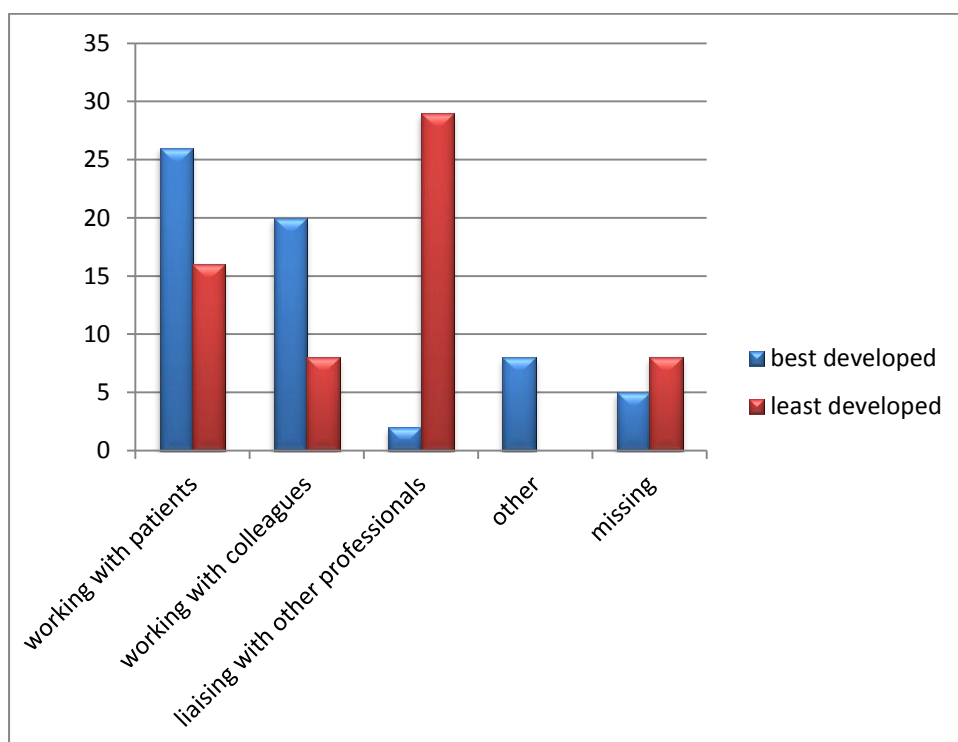


Figure 10: Colleagues' and Employers' relative judgements of New Registrants' communication skills in different situations

A second set of closed questions explored respondents perceptions of New Registrants' interpersonal skills for three aspects of patient management. The results are shown in Table 17 and Figure 11. The majority (56%) of respondents agreed or strongly agreed that New Registrants could explain treatments to patients in ways which were accessible and understandable; but there was far greater ambivalence about the other two statements. Over half (57%) were ambivalent (selecting 'slightly agree' or 'slightly disagree') about New Registrants' responses to patients' anxieties, frustrations and pain; 66% were ambivalent about New Registrants' management of challenging situations (with 20% reporting that New Registrants cannot use interpersonal skills effectively in challenging situations).

New registrants are able to explain treatments effectively to patients in ways which are accessible and understandable	... respond appropriately to patient's anxieties, frustrations and pain using effective verbal and non-verbal skills	... use interpersonal skills effectively in the management of challenging situations (such as unrealistic patient expectations, adverse events, vulnerable patients, etc)
strongly agree	6 (9.8)	3 (3.3)	2 (3.3)
agree	28 (45.9)	14 (23.0)	6 (9.8)
slightly agree	12 (19.7)	26 (42.6)	25 (41.0)
slightly disagree	5 (8.2)	9 (14.8)	15 (24.6)
disagree	5 (8.2)	4 (6.6)	8 (13.1)
strongly disagree	3 (4.9)	3 (4.9)	3 (4.9)
missing	2 (3.3)	2 (3.3)	2 (3.3)
Totals	61	61	61

Table 17: Colleagues' and Employers' evaluations of New Registrants' interpersonal skills

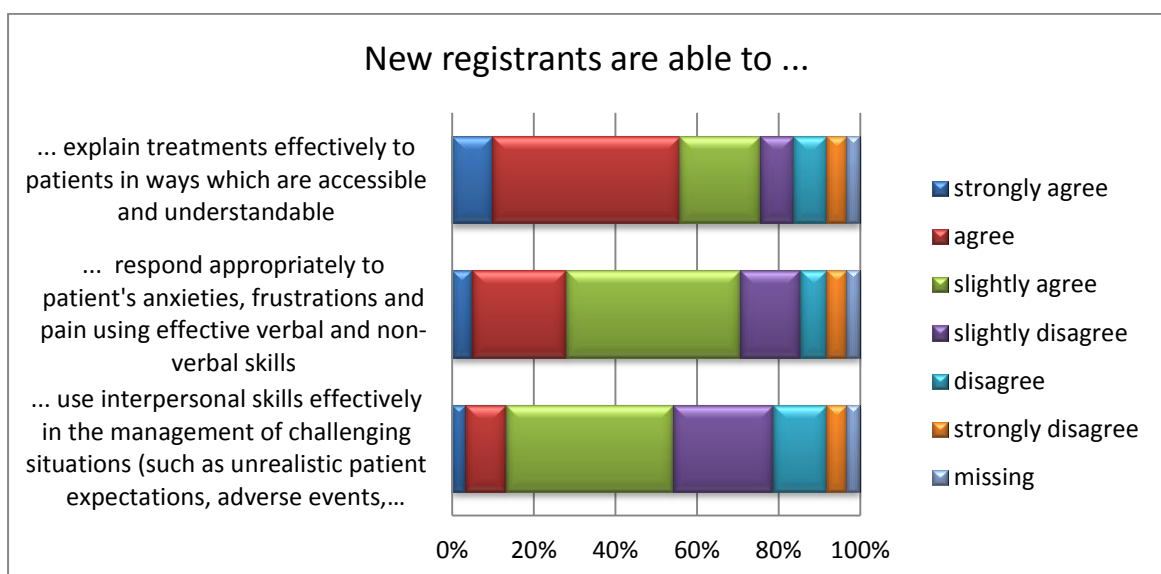


Figure 11: Colleagues' and Employers' evaluations of New Registrants' interpersonal skills

In Chapter 4 we reported Colleagues' and Employers' perceptions of New Registrants' clinical strengths and areas for development (section 4.5.2). Many of the areas reported are highly dependent upon the quality of New Registrants' interpersonal and communication skills, for example strengths in record-keeping and taking thorough case histories; in addition to development needs relating to communicating a realistic prognosis, providing advice that is adequately tailored to patients' circumstances and appreciating the role of interpersonal and communication skills in building and maintaining a patient base. Furthermore, it was reported that a small number of New Registrants were insufficiently aware of the importance of respecting patients' modesty and need for dignity, or they were insufficiently practised in doing this.

It seemed that poor interpersonal and communication skills could substantially reduce the chance of continued employment in group practices. For example, one respondent said:

"In filling in this questionnaire I am taking in to consideration those that are still working at my practice (the good scores) and those that I have had to let go (the bad scores), some had very little communication skills and would not even say hello to patients sitting in the waiting room. Trying to be professional apparently!" (C/E)

This quotation also reminds us of the cross-cutting theme of Diversity, Variability and Uncertainty, which we first identified in relation to clinical skills (Chapter 4) and to which we will return in Chapter 9.

5.4 New Registrants' evaluations of preparedness

Respondents to the New Registrants' Survey evaluated the interpersonal and communications skills learning that occurred during their osteopathy degree in relation to four aspects of professional practice (see Table 18 and Figure 12). New Registrants were very positive. They felt well-prepared for teamwork, making appropriate referrals or relaying advice on future treatment, and managing conflict: 81%, 78% and 72%, respectively, selected well, very well or excellently prepared. While the majority (55%) also felt well-prepared for consulting other professionals, 39% felt they were not very well prepared for this aspect of practice. This echoes the results in section 5.3: Colleagues and Employers thought that liaison with other professionals was the area for which New Registrants' communication skills were least well developed (see Figure 10). Although the question posed on the Colleagues and Employers Survey was not identically worded, there seems to be a mismatch between New Registrants' confidence about their preparedness to manage conflict (Figure 12) and their Colleagues' and Employers' ambivalence about their preparedness to manage challenging situations (Figure 11).

How do you feel your Interpersonal and Communications Skills learning during your degree has prepared you for the following ...	Managing conflict (e.g. difficult clients, unrealistic expectations)	Teamwork	Making appropriate referrals or relaying advice on future treatment	Consulting other professionals
excellently	8 (6.7)	18 (15.1)	14 (11.8)	13 (10.9)
very well	31 (26.1)	34 (28.6)	36 (30.3)	13 (10.9)
well	47 (39.5)	44 (37.0)	43 (36.1)	40 (33.6)
not very well	22 (18.5)	14 (11.8)	18 (15.1)	46 (38.7)
not sure	8 (6.7)	6 (5.0)	5 (4.2)	3 (2.5)
missing	3 (2.5)	3 (2.5)	3 (2.5)	4 (3.4)
Total	119	119	119	119

Table 18: New Registrants' evaluations of degree course preparation in interpersonal and communication skills, applied to four clinical situations

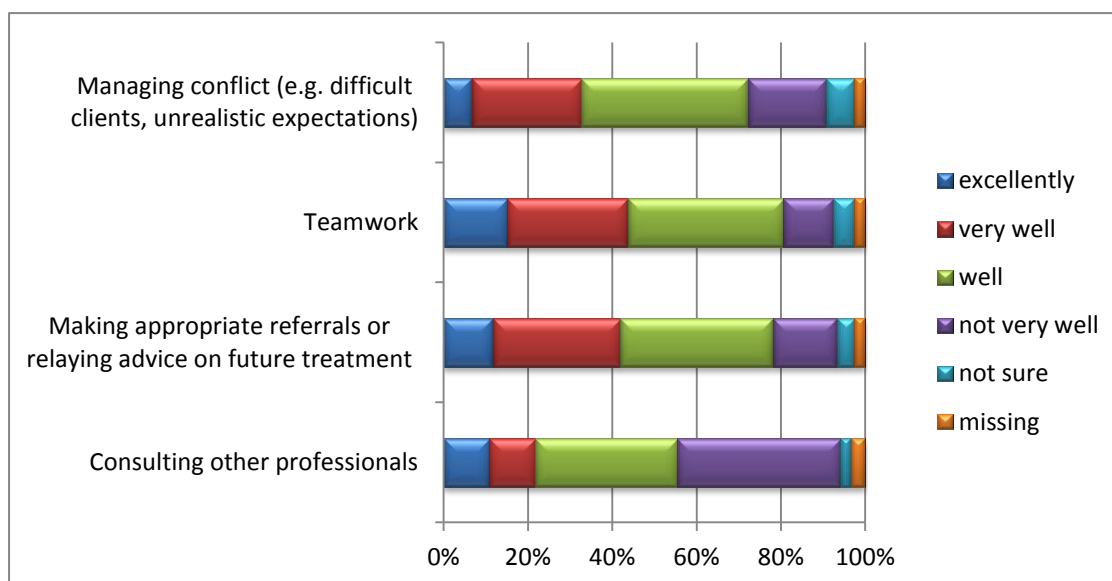


Figure 12: New Registrants' evaluations of degree course preparation in interpersonal and communication skills, applied to four clinical situations

Fifty three (45%) New Registrants provided free-text examples of situations whilst working with patients or colleagues, in which they felt their interpersonal and communications skills had served them well. The examples were very diverse, but recurrent themes included:

- Convincing a patient of the need to see a GP, without over-alarmed the patient.
- Communicating with GPs.
- Explaining what osteopathy is and how it can help.

- Reassuring patients who are nervous of osteopathic treatments, particularly when the nervousness arises from previous experiences of healthcare or complementary therapies.
- Not shying away from the emotions that may be associated with some patients' conditions, for example traumatic injuries or conditions that significantly reduce the quality of daily life.
- Remaining resolute in their professional judgement and practices when under pressure from patients to short-circuit the diagnosis process or to administer treatments the practitioner considers inappropriate.
- Consulting more experienced osteopaths or other professionals when they felt close to the limits of their expertise.

New Registrants also indicated that, having initially been prone to over-optimism, they were developing ways of communicating more realistic assessments of what osteopathy might achieve, and how long and difficult the process might be. The following quotations provide two examples of this:

- *"My patients are more satisfied now that I have learned to give frank, realistic expectations. There is a tendency in early practice to be over optimistic."* (NR)
- *"Recently with a patient who was praising me for my diagnosis I reminded her it was only half the battle and I needed to get to know her and how much treatment she could tolerate, this helped when she was sore after the first treatment."* (NR)

Several New Registrants cited returning patients and patients referring friends as evidence for an inference that their interpersonal and communications skills must be good. Others had confidence in their interpersonal and communication skills as a result of careers they had pursued prior to entering osteopathy.

Thirty nine (33%) New Registrants provided free-text examples of situations during work with clients or colleagues when they felt they needed better interpersonal or communication skills. Again, diverse situations were described, but recurrent themes included:

- When feeling pressurised by patients, for example for particular treatments, for quicker recovery or with patients who were perceived as aggressive.
- Handling strong emotions.
- Making suggestions to more experienced colleagues and resisting pressure from colleagues.
- Persuading patients who are reluctant to see their GP again before treatment continues.
- Feeling *"upset and frazzled"* by complaints from patients (some of which were felt to be justified and some unjustified), then finding it difficult to communicate well in these circumstances; sometimes needing to ask more experienced colleagues to *"step in"*.
- Communicating with the parents of very young babies.

- Working with patients with communication difficulties.
- When patients did not return, New Registrants often blamed the tone or content of their explanations during the previous appointment.

One respondent explained how the quality of clinical thinking can be linked to the quality of communication, which echoed a similar point made in the Colleagues and Employers' Survey. The New Registrant wrote:

"Sometimes if I am unclear of a diagnosis and form a working diagnosis I get a little 'panicky' in my explanation to the patient and tend to over explain my thinking and reasons for being unable to form a definite diagnosis" (NR)

In Chapter 4 we noted that New Registrants felt ill-prepared to work with patients who have mental health needs. Mental health assessments hinge on practitioners' possessing well-developed interpersonal skills, but sometimes it felt as if New Registrants were hoping for something less demanding, perhaps a checklist. The quotation below provides an example:

[Development need] *"ability to screen for psychological / mental conditions (such as, for instance, depression). The effects of mental conditions on physical health are clearly recognised and fit under the heading of holistic well - but apart from lip service there is practically no teaching given to screening for these conditions. This seems in stark contrast to simple screening questions and tests that we might use to for instance determine if a patient needs to be referred to their GP for an endocrine disorder, or for a cardiovascular examination."* (NR)

Finally, we will see in Chapter 7 (section 7.3.2) that a small number of New Registrants struggled to explain potential risks without 'frightening' patients and straining the therapeutic relationship.

5.5 Faculty and final year students' perspectives

Discussions with faculty and final year students yielded interwoven accounts of the learning and teaching of interpersonal communication skills. We begin with the foci for this learning (section 5.5.1), in which the cross-cutting theme of patient safety (Chapter 9) emerges once more. Then we turn to variability and uncertainty in learning and teaching in this area (section 5.5.2). Later, this section will be linked to the cross-cutting theme of Diversity, Variability and Uncertainty (Chapter 9).

5.5.1 Foci for learning and teaching interpersonal and communication skills

The emphasis within curriculum elements that the research participants associated with developing interpersonal and communication skills, shifted between pragmatism (such as how best to get information for purposes such as taking of case histories), humanism and

patient safety (such as working with vulnerable people) and finally, formal forms of communication between different professionals (including legal processes).

The curriculum elements included lectures and some more interactive classes delivered by OEI faculty and visiting speakers, such as psychologists and counsellors, but it was also expected that students would learn a great deal from the role modelling of clinic tutors. Descriptions included the following examples:

- *“I mean they have communication skills lectures which fundamentally look at how to take the case history so how they cover the presenting complaint and then the backgrounds of that and then the general health of the patient but within that they also look at the communication with the patient ...”* (Faculty)
- *“And we have quite a system where letters to GPs, insurance companies, solicitors, they are taught that. In fact in one of the lectures ... I’ve got details there if you want but writing accident reports, acting as a witness in court, all of this is covered so that once they’re out there and this becomes necessary and it is becoming more and more necessary it is nothing new to them.”* (Faculty)
- *“It was mainly on viable communication skills and how to extract information from patients who maybe talk too much or not enough and things, but I can’t remember it being about non-verbal communication”.* (FYS)

The emphasis on communication skills seemed to be geared more towards supporting diagnosis, treatment and requirements for formal communications, rather than interpersonal skills for patient management.

Overall, the impression was that interpersonal and communication skills were a bolt-on addition to the clinical curriculum. Faculty teams realised this is an area for development but were uncertain about how the curriculum should be re-configured to gain maximum impact. There appeared to be no osteopathic consensus about what was needed and how it could be achieved.

We noted in Chapter 4 that some OEIs had good links into community and specialist healthcare and social care services (for instance HIV clinics and homeless centres). The subtext of these learning opportunities was exposure to more unusual pathologies; so exposure to diversity is more clinically focused, rather than one of communication development. Some students picked up on this and suggested that they felt ill-equipped to assess and manage the care of vulnerable people, particularly those with mental health difficulties. Some OEIs had experimented with providing specific support for learning around mental health needs, as the following quotation shows:

“We did do something with I think it was the fourth year, with a counsellor who spent some time with the fourth years, talking about mental health issues and what would happen if a patient presented or you suspected that your patient had mental

health issues and how to respond to that, so it is something that we're aware of and it is something that we encourage our students obviously to take part in those sessions". (Faculty)

Overall, provision was patchy and this concerned students. They were particularly concerned about their skills with respect to assessing, and referring if necessary, patients who may have support needs related to limitations in mental health or mental capacity. One final year student explained her concerns:

"Yes we are exposed to it but it is, in my opinion we are not given the tools to adequately assess people and know where to send them. I think some tutors are guilty of allowing us to treat people who are clearly not able to consent for treatment. So yes I would probably say we need a bit more training." (FYS)

We should note that the student speaks in relation to her understanding of capacity to consent, but it is possible that an experienced osteopath could make a different professional judgement. We make no judgement in relation to the veracity of the student's evaluation, but note that there was a gulf between the student's and the tutor's perceptions. Sometimes such differences of opinion can be fruitful learning opportunities.

New Registrants (section 5.4) and their Colleagues and Employers (section 5.3) drew attention to New Registrants' limited development of some interpersonal and communication skills, which were indeed absent (or very rarely mentioned) in focus group discussions with OEI faculty and students. These included: appreciating the important of communication and interpersonal skills in building and maintaining a patient base; consulting other professionals (other than writing to GPs, which degrees covered); responding to patients' anxieties, frustrations and pain; interpersonal skills for challenging situations; communicating realistic prognoses; challenging more experienced colleagues; persuading patients who are reluctant to see their GP; responding calmly and clearly in the face of complaints; working with patients with communication difficulties, and communicating effectively with babies' parents.

5.5.2 Variation and uncertainty

The narrative content was typified by levels of uncertainty and the identification of variation: another manifestation of the emergent theme of Diversity, Variation and Uncertainty (Chapter 9). Students struggled to discern a strategic plan linking curriculum elements which were focused on interpersonal and communication skills; sometimes even struggling to discern the intended function of some sessions. However, they were pleased that the curriculum paid attention to interpersonal and communication skills, and valued attempts to improve this aspect of their work.

Faculty appeared to be feeling their way toward providing adequate teaching and learning for communication skills (and little attention was directed toward interpersonal skills). One OEI was very candid in this respect, recognising that faculty were struggling to support effective learning about communication. One study participant summarised the situation as follows:

“They get a little ... they get a sort of ... little bit of theoretical delivery I think in the pre-clinic week ...where they do communication and ... But I think some of the tutors actually at a recent event kind of highlighted the fact that they ... they ... one or two of them were finding it hard ... how do I develop the students’ communication skills when I .. you know, I’ve not been trained in that myself, you know and and so it’s one of the things that we identified as a ... as a ... a sort of faculty development [need] actually...” (Faculty)

The uncertainty for students centred on the development of interpersonal skills as being left to chance by observation of clinic tutors and more senior students. Another major issue was how to ensure consistent teaching in the context of: unpredictability surrounding the range of patients a student might meet in clinic; the range of clinic faculty and variation in tutors’ abilities to demonstrate and apply interpersonal and communication skills. Final year students seemed to feel academic and clinic teams assumed students would that they would *“Learn by osmosis”* from observations and exposure to the clinic environment, but further, that this was not made explicit to them as the method of learning. This variability and uncertainty for students was also described in discussions with faculty, for example:

“I think in ... in general it is a challenge for ... all the OEI’s to erm ... erm, to make kind of all the students clinically aware of those kind of range of things. At the moment a lot of clinical education is very much dependent on ... on who walks through the door... so, you know, if you’re a student who sees an angry patient with a ... tutor who has very good communication skills then you might have a really good learning experience in there ... but the other ... fifty-eight students in that year group may not have the same learning experience”. (Faculty)

The reality for students was of mixed experiences – from the very good to the awful. One student described an aspect of this variation as follows:

“... and there’s disparity between tutors who have the respect to take you into their private room to give you feedback if they want to provide you with constructive criticism; and the ones who would not have the social consideration to not take you out of a faculty room which is full of other people. They wouldn’t have the interpersonal skills. They repeat themselves. And seeing other students in the [unclear] get roasted in public, it’s never a nice thing to witness.” (FYS)

Compounding the problem of poor observed role models, students reported that feedback from clinic performance does not always occur during or following clinic sessions. Debriefing and advice on improving performance may be overlooked.

“Well, it should be by feedback from clinic tutors. But for me, clinic tutors don’t spend long enough on case history or talking to a patient to give you that feedback. And you do see some absolute shocking interpersonal skills”. (FYS)

Mature students, in particular, often had confidence in their interpersonal and communication skills as a result of learning during earlier careers and wider life experience. This may of course be true of some mature students, but not others. Nevertheless, there was a sense that students’ perceptions of their pre-existing expertise affected their engagement and evaluation of OEI provision. We noted that faculty did not mention advantages or disadvantages of having confident and mature students within learning groups, even though this must affect the learning and teaching dynamic.

5.6 Summary

Interpersonal and communication skills, as well as being a focus in their own right, underpin the clinical competencies discussed in Chapter 4 and, yet to be discussed, entrepreneurial and business skills (Chapter 6) and professionalism (Chapter 7). In relation to the clinical competences discussed in the previous chapter, the interpersonal and communications skills expertise that New Registrants’ had developed supported their strengths in record-keeping and taking thorough case histories.

New Registrants were positive about their preparedness for the interpersonal and communication aspects of practice. In addition to learning during their osteopathy degree, some New Registrants emphasised how much they had learnt during the careers they pursued before osteopathy. It was clear that New Registrants’ interpersonal and communications skills development had continued in the early months of practice. For example, several indicated that, having initially been prone to over-optimism, they were developing ways of communicating more realistic assessments of what osteopathy might achieve, and how long and difficult the process might be. New Registrants provided a diverse range of examples of situations in which their interpersonal and communication skills had served them well, and similarly, situations when they felt they needed better interpersonal and communication skills. Recurrent themes were extracted, which could help guide curriculum development and postgraduate support.

Colleagues’ and Employers’ evaluations of New Registrants’ interpersonal and communication skills were a little more muted. They felt New Registrants’ interpersonal and communication skills were less well developed than clinical knowledge and skills, but better developed than business skills. They also felt New Registrants were most skilled

when working with patients and least skilled when working with other professionals (as opposed to their direct colleagues). Most felt that New Registrants could explain treatments to patients in ways which were accessible and understandable. However, most had reservations about New Registrants' responses to patients' anxieties, frustrations and pain; their management of challenging situations and liaison with other professionals.

Within OEIs, the importance of communication skills for patient management and accurate clinical intervention was expressed, however, more weight was given to safe clinical practice and the pragmatics of how best to elicit information to support diagnosis. Building relationships as a component of patient management or the skills needed to communicate with other professionals appeared to receive less attention. Specific interpersonal skills learning, was seemingly left more to chance and exposure to observations in clinic. The assumption that observation of clinic tutors will lead to good role modelling may in some cases be true, but not in all cases, as noted by some students. Feedback from clinic tutors was patchy. Though there were some examples of strategic approaches to developing interpersonal and communication skills, the collective voice was that of uncertainty. From a faculty perspective the development of these skills was seen as imperative, but delivery was challenging. Some OEI's recognise this and are actively seeking to develop their curriculum strategy or the pedagogic expertise of faculty whose classes and clinic sessions contribute to the development of students' interpersonal and communication skills. OEI's may need to consider further how they train and support clinic tutors to ensure they are modelling best practice and giving effective feedback. However, New Registrants' were mostly positive about their degree level preparation, so there is much that is positive to build upon.

The narrative content was typified by levels of uncertainty and the identification of variation: another manifestation of the emergent theme of Diversity, Variation and Uncertainty (Chapter 9). One major issue was how to ensure consistent teaching in the context of: unpredictability surrounding the range of patients a student might meet in clinic; the range of clinic faculty and variation in tutors' abilities to demonstrate and apply interpersonal and communication skills.

Chapter 6 Entrepreneurial and business skills

6.1 Précis

New Registrants must build successful small businesses, in difficult economic conditions, under pressure from debt accumulated whilst studying, whilst honing and extending their clinical and interpersonal skills. This is never going to be easy, but realistic expectations and awareness of important principles are likely to help. Study participants emphasised that increased preparedness for running a small business cannot be at the expense of developing clinical competences: safe and reasonably well-accomplished clinical practice is the 'bottom line'.

Although Colleagues and Employers made many criticisms of New Registrants' entrepreneurial and business skills, they appreciated New Registrants' enthusiasm and new ideas for building their businesses. Colleagues and Employers suggested that more could be done during osteopathy degrees to develop realistic expectations of the hard work involved in building and maintaining a patient base. In summary, they felt:

- Graduates needed
 - better understanding of how referral networks function and the importance of interpersonal skills in maintaining or fracturing relationships with patients;
 - better presentation skills
 - to be better at formulating treatment plans with short- and long-term goals and a regular tempo of improvement.
- New Registrants were reasonably good at promoting osteopathy in interactions with GPs but perhaps overlooked similar opportunities with non-medical practitioners.
- Variability in New Registrants' business acumen was based both in personality differences and in career histories.

New Registrants found the transition from student to engaging with the business of osteopathy challenging: 61% of respondents provided examples of the business-related challenges they had faced. Nevertheless 55% were able to give examples of things they had done well to enhance their osteopathic business. As we have seen in earlier chapters, there were diverse experiences and varied perceptions. Learning needs named by some respondents were likely to be named by others as things they had done well. Many New Registrants become osteopaths after working in other small businesses, finance or marketing, for example: these brought more realistic expectations of business and some relevant business skills. In addition, some New Registrants' reported that their earlier careers and hobbies had provided a focus for marketing their new osteopathy practice to people whose needs they could better understand. Their challenges focused on: developing more realistic expectations; financial matters; marketing; understanding how to set up a business and the time and effort required; the slow and effortful process of building a

patient base; identifying a good place to begin to practise; legal matters; isolation and avoiding unfair business practices and 'scams'. It was noted that not everything can be taught in advance of experience and, while New Registrants might begin with "rough skills", these are refined through the experience of joining or starting up an osteopathy business.

Examples from New Registrants who noted business development successes included:

- successful marketing and building relationships;
- appreciating the importance of word of mouth recommendations and developing the patient experience to promote these;
- broadening their clinical skills to be able to offer more treatments;
- in group practices, valuing opportunities for participation in practice management and practice development projects, also appreciating mentorship from colleagues;
- combining part-time work in a group practice with building an independent business;
- building clinical experience through locum work;
- maintaining links with one's OEI to keep abreast of developments and opportunities;
- undertaking business-focused CPD;
- for new businesses, identifying a good location and suitable premises.

Some New Registrants felt tensions between the necessity to earn money and: their feelings of self-worth; their preference for a service-orientation to healthcare; potential conflict between business practices and ethical practice.

There was great uncertainty about the business curriculum and provision varied noticeably across the OEIs. The 'Holy Grail' for faculty was to find the best way to include entrepreneurial and business education, without undermining clinical learning, and such that students would attend activities and evaluate these positively. Discussions centred on timing, level and content. Faculty were struggling to make business education feel "live" at appropriate points in the curriculum. They appeared rather reliant on their own knowledge as practising osteopaths and entrepreneurs, or inviting guest speakers. This approach yielded mixed results. Mature students who had previously been self employed or worked in business environments, felt that they had something to offer as learning agents, often over and above the guest speakers; but faculty did not mention harnessing this expertise within student cohorts.

There was no clear strategy for using clinic experiences to prepare learners for business. Differences in in-house clinic operations could both help and hinder the ability to be more business aware. When students gained experience in specialist clinics, NHS services and social care, or with charities, these were framed as wider access to pathologies not necessarily seen in 'mainstream' clinics, overlooking the possibility that these clinic environments also prepared students for interprofessional and interagency engagement, which could support business development. This study did not encounter any faculty or student narratives around the interconnections between business and patient management. It seems that clinic education could be better-developed.

Students' evaluations of business learning varied from satisfied to very unsatisfied, both in terms of quality and the timing of business-related elements in the curriculum. They had mixed views about the relevance of business skills early in the programme, mainly feeling that this was an unnecessary component compared to osteopathy, but also recognising it was unrealistic to turn attention to entrepreneurship and business skills only in the final months of the course.

Final year students were anxious that business education in college was just an introduction, leaving much self-directed and experiential learning to be completed as New Registrants. Final year students also felt tensions between being an osteopath and being business savvy in order to make a living. Hopes of being a good practitioner tended to override being good at business, leading students to downgrade the importance they gave to business-related education. However they worried about whether they were at risk of being outmanoeuvred by other therapists with more business-focused education and better presence in the marketplace.

6.2 Introduction

This chapter summarises views on preparedness for the business aspects of osteopathic practice, firstly from the perspectives of Colleagues and Employers (section 6.3), secondly the perspectives of New Registrants (section 6.4) and, finally, interwoven narratives from OEI faculty and final year students (section 6.5). We will see that the cross-cutting theme of Diversity, Variability and Uncertainty (to which we will return in Chapter 9), emerges once more.

6.3 Colleagues' and Employers' evaluations of preparedness

In Chapter 4, we reported that Colleagues and Employers ranked business skills as New Registrants' least well developed area of clinical practice (see Figure 6 in section 4.5.2). Many respondents to the Colleagues' and Employers' Survey were somewhat frustrated by the limitations they perceived in New Registrants' business acumen; particularly highlighting that they felt New Registrants had unrealistic expectations about the difficulty of building and maintaining a patient base. Typical comments included the following:

- *"they think patients will just arrive at their door"* (C/E)
- *"Don't let colleges pretend students will have full lists when they start up in private practice, give them far more education in marketing and developing their practice - most only have one or two lectures at best."* (C/E)
- *"Final year teaching must include an element of business management skills both for osteopaths choosing to start as associates in an established practice and those*

choosing to start their own practice. Most new practitioners appear to think that they will arrive at a practice and a full list of patients will magically appear; they need to be taught skills such as identifying potential sources of patients (GPs, NCT, WI, sports clubs, mid-wives, etc) and how to approach them.” (C/E)

Making comments about New Registrants' preparedness for the process of building a patient base turned the thoughts of some respondents toward the general market conditions for osteopathy. Several expressed the view that the supply of osteopathy graduates may have increased too much or too quickly in recent years, risking both over-supply and a shortage of clinical placements for students (with a knock-on effect on subsequent graduates' preparedness to practise). There were concerns that the business conditions for OEIs would drive even further expansion, in the view of the concerned respondents, to the detriment of New Registrants and established osteopaths. We found no evidence supporting or refuting this hypothesised spiral, but did encounter experienced osteopaths who were concerned about how New Registrants would fare in today's difficult economic climate. In addition, some respondents drew attention to the acute pressures facing New Registrants because of debts built up whilst studying. These pressures were felt to be exacerbated for New Registrants who moved some distance from their OEI to begin practising; combining the turmoil of establishing a new home and working life with losses in their social and professional support networks.

Building up speed, gaining confidence and becoming more focused in their investigations and treatment plans were business-related areas for development that we noted in Chapter 4 in relation to clinical competencies. In Chapter 5, we noted that New Registrants reflect on their interpersonal and communication skills in relation to whether patients return and recommend others. Although, later in this section, Table 19 and Figure 13 will show that just over half of respondents thought New Registrants are good at customer care, Colleagues and Employers also identified poorly developed customer focus as a problem for a significant number of New Registrants, although few were as scathing as the respondent who said:

“they behave like patients should be grateful for their attention” (C/E)

Nevertheless, it seems that New Registrants could be better prepared to understand how small businesses build by word of mouth. For example, one respondent suggested:

“They have poor understanding of referral networks and how populations of patients talk and refer new patients. They do not explain how osteopathy can help and [unclear] to help the patient identify areas they could refer their friends for osteopathy.” (C/E)

Colleagues and Employers thought that some New Registrants had a poor appreciation of the full cost of delivering an osteopathy service and paid insufficient attention to minimising unnecessary costs. It was also thought that better presentation skills would help New Registrants to market their osteopathic practice and build a patient base. However, it seemed that only a minority of group practices encouraged New Registrants to become involved in the general marketing of the practice, instead New Registrants' attention was directed toward building an individual patient list. Colleagues and employers thought New Registrants were reasonably good at promoting osteopathy in interactions with GPs but overlooked similar opportunities with non-medical practitioners. It was also felt that to retain patients, New Registrants needed to make better-paced treatment plans, with short and long-term goals and regular interim successes. New Registrants' business acumen and business preparation were compared unfavourably with the preparedness of practitioners from other manual therapies, although we are unable to tell whether this concern has mythical qualities.

Colleagues and employers drew attention to the variability of New Registrants' business acumen, based both in personality differences and in career histories. Many New Registrants become osteopaths after working in other small businesses, finance or marketing, for example: these brought more realistic expectations of business and some relevant business skills. On the other hand, some Colleagues and employers thought that those who lacked prior work experience struggled, for example:

“When new registrants have no other background, e.g. have trained as osteopaths from school, some are entrepreneurial, but many are lost. They have youth and energy on their side, but no management skills and low levels of interpersonal skills/empathy/expectation management.” (C/E)

In response to a series of closed questions about business acumen, just over half (52%) of respondents agreed or strongly agreed that, in their experience, New Registrants are good at customer care (see Table 19 and Figure 13). However, there was substantial ambivalence (a third selecting 'slightly agree' or 'slightly disagree') and even greater ambivalence with respect to New Registrants' expertise in relation to budgets, strategic and ongoing developments, and marketplace awareness (54%, 49% and 48%, respectively, ambivalent). Indeed, 25%, 33% and 31% of respondents disagreed or strongly disagreed with the statements of New Registrants' expertise relating to budgets, strategic and ongoing developments and marketplace awareness. Furthermore, when Colleagues and Employers were asked: 'To what extent do new registrants understand the interface between clinical practice, customer care and business growth?' the modal response (31, 51%) was 'not well' (see Figure 14).

New registrants I have worked with are good at customer care	... are good with budgets	... are good with strategic and ongoing developments	... have good marketplace awareness
strongly agree	7 (11.5)	0	2 (3.3)	3 (4.9)
agree	25 (40.1)	8 (13.1)	7 (11.5)	8 (13.1)
slightly agree	17 (27.9)	22 (36.1)	15 (24.6)	13 (21.3)
slightly disagree	3 (4.9)	11 (18.0)	15 (24.6)	16 (26.2)
disagree	6 (9.8)	7 (11.5)	12 (19.7)	9 (14.8)
strongly disagree	2 (3.3)	8 (13.1)	8 (13.1)	10 (16.4)
missing	1 (1.6)	5 (8.2)	23.3)	2 (3.3)
Totals	61	61	61	61

Table 19: Colleagues' and Employers' perceptions of four aspects of New Registrants' business acumen

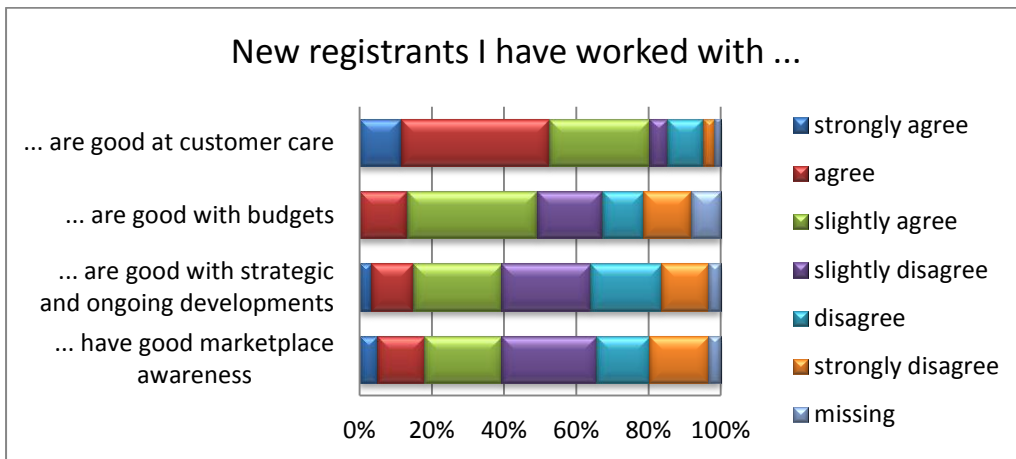


Figure 13: Colleagues' and Employers' perceptions of four aspects of New Registrants' business acumen

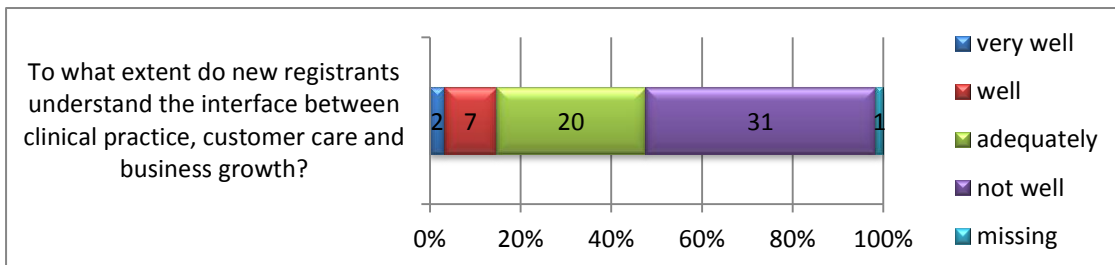


Figure 14: Colleagues' and Employers' evaluations of New Registrants' understanding of business interfaces

There was general agreement that osteopathy students need some help to develop business awareness and sound business practices, because such a high proportion of New Registrants are self-employed and many practise alone. It was also suggested that generations of osteopaths had muddled through after beginning their careers with poor business acumen. Although, by definition, experienced colleagues had become successful in business, some were nervous about the quality of their business expertise for the purpose of mentoring New Registrants (unlike the quality of their clinical expertise, of which they were proud). However, respondents cautioned that any increased emphasis on entrepreneurial and business expertise to improve New Registrants' preparedness for this aspect of practice, could be to the detriment of focus on clinical capability. One respondent summarised the view expressed by many that the central focus of osteopathic education must continue to be safe and sufficiently accomplished clinical practice:

"I consider clinical capability far more important than business skills in providing a high standard service to patients and the public, so business acumen is not something I 'major' on, or particularly want colleagues to do." (C/E)

In short, there is a great deal that New Registrants need to be good at. One respondent summarised expectations as follows:

"Forgot to mention poor business skills in the earlier part - but that is always poor but they learn on the job - if they go to an efficient practice who can teach them. They need more emphasis on clinical/osteopathic hands on skills. Help with treatment planning and spacing. This should be tackled by a responsible Principal who is in the clinic at the same time as the new registrant. There seems to be no knowledge of any exercise or self help for the patient, again this can be done in practice but there should be a base level." (C/E)

Despite many criticisms of New Registrants' entrepreneurial and business naivety, there was also appreciation of the value of their enthusiasm and new ideas.

6.4 New Registrants' perspectives

New Registrants found the transition from student to engaging with the business of osteopathy a challenging transition. For example, one said:

"I feel the course trained me to be a great practitioner, but unfortunately without proficient business knowledge I have found getting started to be the hardest aspect of my practice." (NR)

Nevertheless most (65, 55%) respondents were able to give examples of things they had done well to enhance their osteopathic business; beginning with the most frequent, recurrent examples included the following:

- Successful advertising or marketing (websites, social media, leaflets, networking, talks, local press articles, open-evenings). One respondent summarised his approach as: *“Being enthusiastic about what I do, and communicating this through electronic media, networking sites, friends and family.”* (NR)
Respondents also mentioned the importance of analysing responses to marketing and undertaking targeted marketing for identified groups such as members of sports clubs. Some specifically targeted the employment fields in which they had previously worked.
- Building relationships with GPs, physiotherapists, chiropractors and a range of other healthcare practitioners; also networking in the local community.
- Appreciating the importance of word of mouth recommendations and then trying to provide very good patient experiences to increase the likelihood of such recommendations. New Registrants’ perceptions about the facets of providing a good patient experience most often included interpersonal skills (see Chapter 5) such as building a good rapport, providing ample explanation, maintaining a professional manner and putting patients at ease. Another focus was efficient administration for appointments, billing and insurance claims. Finally, some respondents mentioned safe practice and good clinical outcomes. Comments in each of these areas included the following:
 - *“I have treated patients fairly and truthfully I explain to the patient in detail what their problem is (which they always like to know because they then feel there is a reason for treatment even if they feel better after the first session).”* (NR)
 - *“I’ve managed to create a practice where people feel comfortable and at ease. It’s a therapeutic space.”* (NR)
 - *“Treating patients with good outcomes therefore more word of mouth”* (NR)
- Broadening one’s clinical skills to enable one to offer more treatments, examples included: acupuncture, neonatal assessment and sports injury rehabilitation.
- If working in a group practice, it was useful to take up opportunities for participation in the management of the practice and practice development projects. Respondents also noted the value of mentorship from experienced colleagues.
- Combining part-time work in a group practice with part-time work building an independent business.
- Building clinical experience through locum work.
- Maintaining links with one’s former OEI to help keep abreast of developments in osteopathy and business opportunities.

- Undertaking business-focused CPD (and one respondent had worked with a business mentor).
- For those setting up new businesses it was important to identify a good location and suitable premises.

On the other hand, 73 respondents (61%) identified areas in which they would have liked their preparedness for engaging in business to have been stronger. We will see that some areas named as weaknesses here, were among the preceding list of things that other New Registrants thought they had done well. This echoes the findings in earlier chapters, which drew attention to the diversity of New Registrants strengths and perceptions. Returning to development needs, the strongest theme was more realistic expectations about various facets of entering osteopathic business practice. Respondents also had specific learning needs: some of which, for example effective marketing, are amenable to advance development through academic study. Other aspects of business knowledge, for example regulation and taxation, are very detailed and change too frequently for advance preparation beyond awareness, broad principles and skills for information retrieval. Beginning with the most frequent, recurrent themes in respondents comments included:

- Financial matters, particularly accounting and book-keeping, but also: taxation, insurance claims, setting fees and recovering unpaid fees; along with realistic expectations of remuneration and costs.
- Better understanding of how to focus marketing effectively and thereby reduce marketing costs.
- Greater understanding of how to set up a business, develop a business plan and access any support that may be available for small businesses; alongside more realistic expectations of the amount of work involved, business costs and the time taken to break even.
- More realistic expectations about the time and effort required to build a patient base.
- How to identify a good place to start a business and suitable premises; or how to identify a good practice to join as an associate (some concerns were voiced about perceptions that New Registrants could be exploited or insufficiently supported in some practices).
- Legal matters such as registrations, insurances, contracts and relevant legislation.
- Some New Registrants felt they had fallen victim to unfair business practices and 'scams'.

Typical comments about learning required in relation building an osteopathic practice are provided in Figure 16 (on page 93). Many respondents explicitly or implicitly indicated that such learning ought to be identifiable curriculum elements within osteopathy degrees. However for some, these learning needs were more about the informal curriculum and generating more realistic expectations through the (overt and subliminal) messages projected throughout osteopathy degrees and even during recruitment to these degrees. Examples of concerns about projected messages are provided in Figure 15.

- Biggest challenge in transition from education to practice: *“the cost and difficulty of attempting this (I feel we are told/taught to expect too much from osteopathy)”* (NR)
- *“I feel that the difficulty of building/starting a practice/patient list/establishing yourself as an osteopath is wholly overlooked and not outlined properly at university”* (NR)
- *“I feel we were unprepared for the realities of starting out with so much competition in a recession. All the tutors gave the impression I would be earning well, their information is incorrect in about 70% of cases from what I hear from peers.”* (NR)
- *“I understand the necessity to advertise osteopathy favourably to attract potential students but the difficulties in transitioning from student to practitioner should have been clearer in the final years of study.”* (NR)

Figure 15: New Registrants' concerns about over-optimistic portraits of osteopathy practice

Nevertheless, not everyone thought that osteopathy graduates had business-related gaps in their preparedness to practise. One New Registrant wrote:

“None - this was well taught”. (NR)

Another had the self-awareness to highlight that not everything can be taught in advance of experience:

“The importance of being able to have successful treatment outcomes with Low Back Pain; neck pain. Simple as that, as that is the predominant presentation in clinic and the more successful the treatment outcome the stronger the word of mouth endorsement (WoM = 80% of referrals). This one fact never struck home during training (One can hear but not fully appreciate until in practice).” (NR)

One New Registrant linked building an osteopathy business to the development of clinical expertise. He talked of refining both clinical and business expertise in a way that echoed the emphasis, reported in Chapter 4, which Colleagues, Employers and New Registrants placed on building experience and refining practice. He wrote:

“My degree gave me some rough skills but not enough to adequately compete in private practice against more experienced osteopaths and chiropractors. I have been able to refine my techniques, knowledge and experience to the point that nearly 2 years after qualifying I run my own clinic and locum for a chiropractor.” (NR)

- *“May be the school should make some room in the last year for some real practical stuff about the fact that student are out in the world and should learn business survival skills.”(NR)*
- *“Becoming business orientated. The course taught me how to be a clinician which is fine if I was working within the NHS or for a practice, but as I worked for myself I had to develop these skills - which take time.” (NR)*
- *“Building up a cross referral base with as many other health care providers as possible. Perhaps this could be looked into when still studying.” (NR)*
- *“how hard it is to start up (lots of patience required)” (NR)*
- *“how slow it is to get started” (NR)*
- *“how to be a technically trained professional and a promote new business at the same time” (NR)*
- *“How to manage patients to ensure growth of the business” (NR)*
- *“I would have liked a short course on setting up practice in the last year of college.” (NR)*
- *“I would like to have learned DURING my course simple business strategies and various business models related to building a successful practice from scratch. basic accounting and marketing tools” (NR)*
- *“I would liked to have had more of the degree devoted to the methods most relevant for establishing and developing a practice, this was one of the least developed areas of the course. I am led to believe that the chiropractic degree devotes more time to this.” (NR)*
- *“We had an excellent talk from [name] on marketing but could have done with more of that kind of information” (NR)*
- *“more on finance, business plans etc (we only had 2-3 afternoons and they were really helpful)” (NR)*
- *“Marketing that doesn't work for osteopathy, marketing that DOES work for osteopathy.” (NR)*
- *“We need more advice in how to deal with referrals, letter writing, all the basic stuff that makes a business look professional. And therefore our reputations begin high at the start and stay high with our treatments.” (NR)*
- *“More realistic expectations of what's possible in the first year.” (NR)*
- *“Much more on practice-building, pitfalls and the length of time required to earn money.” (NR)*
- *“running the business is challenging, the human aspect of management as well as developing skills in marketing.” (NR)*
- *“Running your own business - I had no idea where to start and have made quite a few mistakes along the way.” (NR)*
- *“Understanding that graduating may make one a safe osteopath but not a business savvy one.” (NR)*
- *“waiting for the phone to ring can be very challenging, even soul destroying.” (NR)*
- *“What are fair expectations and arrangements when working as an associate” (NR)*
- *“What do the successful practices do to bring in patients and where/how/what did they look for in a practice/area.” (NR)*

Figure 16: New Registrants' comments on business-related learning needs

Some New Registrants found it particularly challenging to balance the necessity to earn money with their feelings of self-worth or a preference for a service-orientation to

healthcare. They also felt tensions within the need to combine sound business practices with ethical practice. A selection of their comments is included in Figure 17. Others felt very isolated, or that isolation was a necessary part of building a successful business. The next two quotations illustrate these slightly differing emphases and we will return to isolation in Chapter 9:

- *“once you are out there, you are on your own. The university clinical world where you are surrounded with osteopath you can practice with and you can ask questions to, is not there anymore (in my case at least, maybe some can find it again in some practice they will work for). Like any other decision, any business decision is on you.”* (NR)
- *“Osteopathy is just one of many therapies competing for custom in an overcrowded market particularly the south east and you face the prospect of maybe having to move to a location far away from your existing support network to find sufficient employment.”* (NR)

- *“Balancing the fact that the patients may need treatment and how much they are paying me. Looking more at the money-side of things rather than just looking at how to best help the patients. It's truly a balancing act that we are not taught during the degree course”* (NR)
- *“dealing with the overwhelming responsibility of managing patients expectations when they are paying a full fee and expect quick results.”* (NR)
- *“Learning to realise that what you do is worth being paid for. Initially I felt guilty for taking people’s money after treating them. The reason for this, is that I know what needs to be done and some things are quite simple (and also they do not directly pay for NHS so it feels weird that they have to pay us for treatment), but now I am used to the fact that they do not know what we know and therefore they are really paying for our knowledge and advice.”* (NR)
- *“Necessity to actually make money / be commercially minded in what I had always viewed as a service profession.”* (NR)
- *“The single biggest challenge is the balancing of clinical versus business needs, in terms of maximising income from client base whilst maintaining ethical treatment.”* (NR)
- *“Working in a clinic as a course requirement with no worry about the financial issues and then trying to make a living without being unethical.”* (NR)
- The challenge of: *“Not feeling you have to get everyone better in two or three sessions through over-treating whilst you have more time initially (as patient numbers are lower). You need to understand that you are running a business and follow up patient numbers are an important element in terms of income generation, though obvious this needs to be balanced with appropriate/ethical approach to patient care.”* (NR)
- *“the challenges that arise from expectations from patients; these can be nerve-wrecking as they are paying a substantial amount for treatment and have very high expectations. Furthermore, the patient base dealt with is also of a certain type from affluent backgrounds - professionalism is of paramount importance.”* (NR)

Figure 17: New Registrants' views on building a business in relation to their feelings of self-worth, service-orientation and ethical practice

6.5 Faculty and students' perspectives

As osteopathy exists in a competitive environment where many manual and complementary therapists are vying for business, the business acumen required by members of the profession cannot be overlooked; but this needs to be managed sensitively and practically to ensure the integrity of the profession, as clinically grounded. In relation to other parts of the curriculum, such as anatomy, physiology, or osteopathic principles and clinic experiences, business can be seen as a less important learning focus: particularly in view of the emphasis on patient safety, reported in Chapter 4, to which we will return in Chapter 9. The 'Holy Grail' for faculty was to find the best way to include entrepreneurial and business skills in the curriculum, without undermining clinical learning, and such that students would attend activities and evaluate these positively. Discussions centred on timing, level and content. Firstly on timing in terms of which years of study were best suited to elements of the business curriculum; secondly, the issue of timing in relation to clinical aspects of the curriculum, particularly practical and theoretical assessments. Decisions about level were complicated by the diversity of students' business learning needs, due to heterogeneous groups in which some students brought relevant expertise from earlier careers.

Curriculum provision for entrepreneurial and business skills varied noticeably between OEIs, but everywhere faculty were struggling to make this provision feel "live" at appropriate points in the curriculum. They appeared rather reliant on their own knowledge as practising osteopaths and entrepreneurs, or inviting osteopathic practitioners into the OEI to discuss how they run their practice. Some had also invited business development agencies, accountants, or tax specialists in to meet with students, but this approach yielded mixed results, with some students getting good input, while to others it appeared that some guest speakers were more interested in promoting their own business interests than providing sound business education, focused on the particular needs of osteopathy graduates. The use of multiple guest speakers could feel uncoordinated and lacking a learning strategy. Mature students who had previously been self employed or worked in business environments, felt that they had something to offer as learning agents, often over and above the guest speakers; but faculty did not mention harnessing this expertise within student cohorts.

Students' experiences of business learning varied from satisfied to very unsatisfied, both in terms of quality and the timing of business-related elements in the curriculum. They had mixed views about the relevance of business skills early in the programme, mainly feeling that this was an unnecessary component compared to osteopathy, but also recognising it was unrealistic to turn attention to entrepreneurship and business skills only in the final months of the course. Nevertheless, at one OEI there was some consensus between faculty and students that offering a business-oriented between final examinations and graduation

was an appropriate place for learning that was immediately relevant to future practice. The extract from a faculty focus group discussion in Figure 18 illustrates this and, as an example, one student suggested:

“Towards the end, you’ve got a few weeks after the exams are finished now, obviously a bit late in the day. But people are keen to be... It’s probably a bit late now, but this year would have been a good year. We could have not done some of the other rubbish”. (FYS)

That said, one OEI had recently implemented a programme which has a ‘business’ module in each year of the five-year programme. This would be worth evaluating for its impact and effect on the student experience.

PAR1	<i>“That’s right so business development workshops and commercial aspects of which again we feel ... we left this to the end because now the exams are over the students are able to relax and best able to receive these final touches ...”</i>
PAR2	<i>“Absolutely and they really take these things really seriously with a more meaningful, because they’re, in a few weeks they’re out there, so they really work well at this time of the year”. (Faculty)</i>
PAR1	<i>“... they’re cramming for finals and ... and stuff like that...and maybe embedding it from earlier would be better. But I ... I think it’s a ... I think it’s a really difficult problem. But embedding it earlier, as I found out ...They don’t turn up... they don’t turn up because they don’t see the relevance”. (Faculty)</i>

Figure 18: Faculty focus group extract about timing of business-related curriculum elements

There was no clear voice which outlined a strategy for using clinic experiences to prepare learners for business. Differences in clinic operations could both help and hinder the ability to be more business aware. In some clinics, students concentrated solely on improving osteopathic skills, with no responsibilities for other aspects of running the clinic, not even booking in or making follow up appointments. These students functioned in very stable and professional environments, which were good for developing clinical techniques but did not contribute to realistic expectations of private practice, or to developing business expertise. One OEI had involved students in developing the marketing of the in-house clinic, which was one example of creating synergy between the clinical and business elements of the course. Other clinics operated from small community bases and students were involved in reception, administrative, and general managerial duties as part of clinical osteopathic duties. Some students had gained experience in specialist clinics, linked to NHS provision, social care or with charities. We saw in Chapter 4 (section 4.6.1) that these clinic experiences were framed as wider access to pathologies not necessarily seen in ‘mainstream’ clinics: there was little mention of the possibility that these clinic environments also prepared students for engagement with other allied health professions and medicine; which New Registrants (section 6.4) and their Colleagues and Employers (section 6.3) would identify as an important aspect of the difficult task of building a patient

base. These contrasting examples of clinic-based learning each had their own logic, strengths and weaknesses as learning environments, but there was great variation in the degree to which students had systematic exposure to a range of clinic experiences, such that clinical, interpersonal, business and ethical expertise could all grow. This study did not encounter any faculty or student narratives around the interconnections between business and patient management. It seems that clinic education could be better-developed.

Final year students appreciated that entrepreneurship was complex and variable, so there was no sense of learning *'the'* way to do it: more about exposure to some ideas, guiding principles and some knowledge of regulations. One student said:

"Really quite a lot. We've had all the people come in and give us official talks, how you stand with inland revenue and sort of the official bodies, but we've also had loads of people come and talk to us like personal experience of what they've done, how they've done it, because there's no set route". (FYS)

This quotation also highlights another manifestation of the emergent theme of Diversity, Variability and Uncertainty.

Nevertheless, final year students were anxious that business education in college was just an introduction, leaving much self-directed and experiential learning to be completed as New Registrants. One student provided an example:

"We had an accountant come in for, two times and went through quite a lot of stuff but there wasn't enough time to really get our heads around it because it is obviously something we've never, unless you have been self-employed before we've never come across this sort of stuff. So I feel really ill equipped for the coming of self-employed". (FYS)

Just as we saw with New Registrants' (section 6.4), final year students thought about the components of desired business education in terms of practical business skills and wider principles for professional practice. One student illustrated this combination:

"Things like what we're talking about now, things like ethics, things like being aware of these regulations, things like setting up a practice. I would have thought it would be a good thing for that to be something that is structured in so that everybody gets that sort of instruction. I think that's a deficit". (FYS)

Final year students also felt tensions between being an osteopath and being business savvy in order to make a living, particularly since some had had chosen this career as a means to have flexible work and autonomy as a self employed practitioner. Hopes of being a good practitioner tended to override being good at business, leading students to downgrade the

importance they gave to business-related education. The quotation below demonstrates some of this ambivalence.

“Like it’s not like we’re setting up a major business, there are obviously quite a few aspects to it, but you know, being an osteopath is the hardest part, being a clinician and all the rest of it. So it is essentially something that it’s not our main focus, so it never clashed for me I think”. (FYS)

However, students were anxious that their preparedness for business was less than those who had studied to be chiropractors. They described “an uneven playing field” with osteopathy graduates perhaps badly positioned – they felt they might be good practitioners but worried about whether they were at risk of being outmanoeuvred by other therapists with more business-focused education, particularly in marketing, and better presence in the marketplace. One student voiced this very common concern, whilst also revealing great uncertainty, which is one of the emergent themes we have already identified to be discussed in Chapter 9:

“I think slightly... Not a relevant point, but when we were talking earlier about business type things and realistic type stuff. You know, you hear how true is... I don’t know, the chiropractic students, particularly, are very well educated or drilled or informed about how to go out, how to set up a good business, this, that and the other. And that gives them an edge in reality, I think. And I think that’s something that we lack. You know, I think in terms of...” (FYS)

This study did not examine chiropractic education, so cannot comment on the accuracy of this common perception.

6.6 Summary

New Registrants need to build successful small businesses, in difficult economic conditions, under pressure from debt accumulated whilst studying, whilst honing and extending their clinical and interpersonal skills. This is never going to be easy, but realistic expectations and awareness of important principles are likely to help. Study participants emphasised that increased preparedness for running a small business cannot be at the expense of developing clinical competences: safe and reasonably well-accomplished clinical practice is the ‘bottom line’.

Although Colleagues and Employers made many criticisms of New Registrants’ entrepreneurial and business skills, they appreciated New Registrants enthusiasm and new ideas for building their businesses. Colleagues and Employers suggested that more could be done during osteopathy degrees to develop realistic expectations of the hard work involved

in building and maintaining a patient base. They drew attention to the variability of New Registrants' business acumen, based both in personality differences and in career histories.

New Registrants found the transition from student to engaging with the business of osteopathy challenging. As we have seen in earlier chapters, there were diverse experiences and varied perceptions. Though most students graduate feeling "*safe*" and therefore well prepared for clinical practice, their position as commercially astute practitioners was more precarious. In relation to other parts of the curriculum, business can be seen as a less important learning focus: particularly in view of the emphasis on patient safety, reported in Chapter 4. It was also noted that not everything can be taught in advance of experience.

For faculty the 'Holy Grail' for faculty was to find the best way and the best time to include entrepreneurial and business education, without undermining clinical learning, and such that students would attend activities and evaluate these positively. Decisions were complicated by to heterogeneous groups in which some students brought relevant expertise from earlier careers; but faculty did not mention harnessing this expertise within student cohorts. There was no clear strategy for using clinic experiences to prepare learners for business.

Chapter 7 Professionalism

7.1 Précis

Professionalism is a complex and diffuse concept, which does not stand aside from other aspects of expertise, but rather infuses these with values, attitudes and actions that are patient-centred and empowering, collaborative, ethical, self-aware and aligned with osteopathic values and principles. Consequently we have already touched on aspects of professionalism in other chapters, particularly: the emphases on safety and communication with patients within clinical education; noting variable preparedness for interprofessional collaboration with other healthcare professionals; also recognition of the interplay between professional behaviours and building a successful osteopathic business. In this chapter we summarised data pertaining to additional aspects of professionalism, viz: osteopathic values, standards for practice, evidence-based practice, reflective practice, self-evaluation and engagement with continuing professional development.

There was no consensus about osteopathic values. This linked to two emergent cross-cutting themes which will be addressed in Chapter 9: 'Diversity, Variability and Uncertainty', and 'Autonomy and Isolation'. Distinctive preparations for practice provided by different OEIs appeared to lead to some segmentation of employment opportunities. Despite the lack of consensus about the nature of osteopathic values 64% of respondents to the Colleagues' and Employers' Survey agreed or strongly agreed that New Registrants show strong evidence of osteopathic values.

In a context of different emphases within OEI programmes, Standards for Practice were important to ensure common thresholds for preparedness to practice. The Standards were embedded in osteopathy curricula, partly due to accreditation requirements, but also because faculty were preoccupied with preparing students for autonomous, independent practice; due to the high prevalence of self-employment and lone practitioners. All stakeholder groups expressed high levels of certainty that New Registrants were familiar with the GOsC Standards for Practice. Responses in relation to the use and usefulness of the standards in daily practice were more muted but still generally supported. Both students and New Registrants were most exercised about the Standards relating to communicating risks and benefits, and ensuring consent.

Consideration of evidence-based practice (EBP) prompted discussion of different understandings of the nature of evidence in relation to osteopathic practice and some concern about the role of EBP in enhancing or damaging the profile of osteopathy as a valid alternative to medicine and manual therapies such as physiotherapy and chiropractic. Students and New registrants were confident about their understanding of EBP, but highlighted a gap between understanding and the ability to enact EBP in daily practice. They

and faculty highlighted the poor availability of evidence (however defined). This had two components: firstly, osteopathic evidence was felt to be in particularly short supply. Secondly, students and New Registrants were concerned about rather limited free or affordable access to bibliographic databases, journals, books and other resources for practitioners outside of OEIs. Study participants identified the physiotherapy literature as a fruitful source of evidence to support osteopathic practice.

Professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. The great majority of respondents to the New Registrants' Survey (76%) were confident that they could recognise their strengths and weaknesses. Results reported in earlier chapters have shown that New Registrants readily identify strengths and areas for development in different aspects of their practice. They provided a large number and range of examples, which were summarised in the preceding chapters and linked to the cross-cutting theme of 'Diversity, Variability and Uncertainty' (Chapter 9). The accuracy of New Registrants' self-evaluations is difficult to gauge, although the data from Colleagues and Employers highlights variability: both individual variability in self-awareness and at aggregate levels across different areas of professional practice.

Professionalism requires that, working hand in hand with reflection leading to realistic self-evaluations, practitioners engage in career-long learning to update, refine and expand their expertise. This study found that the vast majority of respondents to the New Registrants' Survey (88% of the 2009 cohort and 84% of the 2010 cohort) had participated in CPD, even though the 2010 cohort were largely still exempt from GOsC CPD requirements. Respondents provided a very wide range of examples of CPD participation, mainly focused on additional clinical skills and related underpinning knowledge in order to expand their repertoire of diagnostic and treatment skills, most often cranial work or acupuncture; some focused on developing their expertise with respect to specific patient groups, most often children; while some had focused on business-related CPD. Self-study, attending practice-based CPD and local and regional CPD groups were all popular, reflecting New Registrants concerns about the cost of many CPD opportunities. Nevertheless many had attended short-courses or conferences, or undertaken more substantial programmes of study, sometimes leading to additional qualifications.

Within OEIs the main activity associated with self-evaluation and commitment to career-long learning was the promotion of reflective practice, although this had a relatively short history at some OEIs.

7.2 Introduction

Professionalism is a complex and diffuse concept, which does not stand aside from clinical expertise (Chapter 4), interpersonal and communication skills (Chapter 5), entrepreneurial and business expertise (Chapter 6) and commitment to supporting the development of

inexperienced colleagues (Chapter 8); but rather, infuses all these aspects of practice with values, attitudes and actions that are patient-centred and empowering, collaborative, ethical, self-aware and aligned with osteopathic values and principles. Consequently we have already touched on aspects of professionalism in other chapters, for example: an emphasis on safety in clinical education (Chapter 4); uneven preparedness for collaboration with other health professionals (Chapters 4-6); recognition that excellent communication and working in partnership with patients, sets realistic expectations, guides treatments plans and improves patient satisfaction, leading to the word of mouth referrals which are essential to building a patient base for a successful business (Chapters 4-6); but the need to build a business, unless curbed by professionalism and ethical practice, could encourage over-treatment at the expense of promoting self-help or making appropriate referrals (Chapter 6). During this study we prompted comments on three additional aspects of professionalism, viz: osteopathic values and standards for practice (section 7.3), evidence-based practice (section 7.4), engagement with continuing professional development, reflective practice and self-evaluation (section 7.5). Discussions of professionalism drew attention to the cross-cutting theme of autonomy, which will be described in Chapter 9.

7.3 Osteopathic Values and Standards for Practice

At the time of this study two versions of standards for practice were in circulation:²⁸ the documents *Code of Practice*²⁹ and *Standard 2000: standard of proficiency*³⁰ (commonly termed S2k) were in force and, together, provided standards for practice; but updated standards for practice, *Osteopathic Practice Standards*³¹ were already in circulation in preparation for replacing the earlier documents from 1 September, 2012. When study participants referred to standards for practice, we cannot be certain about the extent to which they were familiar with, and differentiated between, both versions of the standards for practice; although sometimes study participants referred to particular clauses in identifiable documents.

7.3.1 Colleagues' and Employers' perspectives

Using a six-point Likert scale, members of the Colleagues and Employers group rated four statements about New Registrants' understanding and application of osteopathic values and GOsC standards for practice. The results are summarised in Table 20 and Figure 19. The majority agreed with each statement: most certainty (72% agreed or strongly agreed) was associated with the statement, 'New Registrants are familiar with the GOsC standards for practice'. Other statements attracted 60-70% agreement (64% for strong evidence of osteopathic values; 67% for transferring GOsC standards into daily practice and 61% for good application of osteopathic values and standards). These results may not be as good as they seem at first glance: knowing and applying the relevant standards for practice is a requirement for ongoing registration as an osteopath. Reported ambivalence (selecting

slightly agree or slightly disagree) of between 21% and 28% (and disagreement of up to 7%) may signal that this area of preparedness to practise may be insecure for a 20-30% of New Registrants. In addition, the ambivalence (21%) and disagreement (11%) with the statement ‘New Registrants show strong evidence of osteopathic values’ could arise from diverse and contested views about osteopathic values (see section 7.3.3). In fact one respondent wrote:

“I don't understand your term Osteopathic Values. This seems isolationist” (C/E)

New Registrants...	... show strong evidence of osteopathic values	... are familiar with the GOsC standards for practice	... are transferring the GOsC standards into their everyday clinical practice	... apply their osteopathic values and standards well in clinical practice
	Frequency (%)	Frequency (%)	Frequency (%)	Frequency (%)
strongly agree	14 (23.0)	16 (26.2)	12 (19.7)	11 (18.0)
agree	25 (41.0)	28 (45.9)	29 (47.5)	26 (42.6)
slightly agree	7 (11.5)	9 (14.8)	12 (19.7)	13 (21.3)
slightly disagree	5 (8.2)	4 (6.6)	3 (4.9)	4 (6.6)
disagree	3 (4.9)	1 (1.6)	2 (3.3)	3 (4.9)
strongly disagree	4 (6.6)	1 (1.6)	1 (1.6)	1 (1.6)
Missing	3 (4.9)	2 (3.3)	2 (3.3)	3 (4.9)
Totals	61	61	61	61

Table 20: Colleagues’ and Employers’ evaluations of New Registrants’ understanding and application of osteopathic values and GOsC Standards for Practice

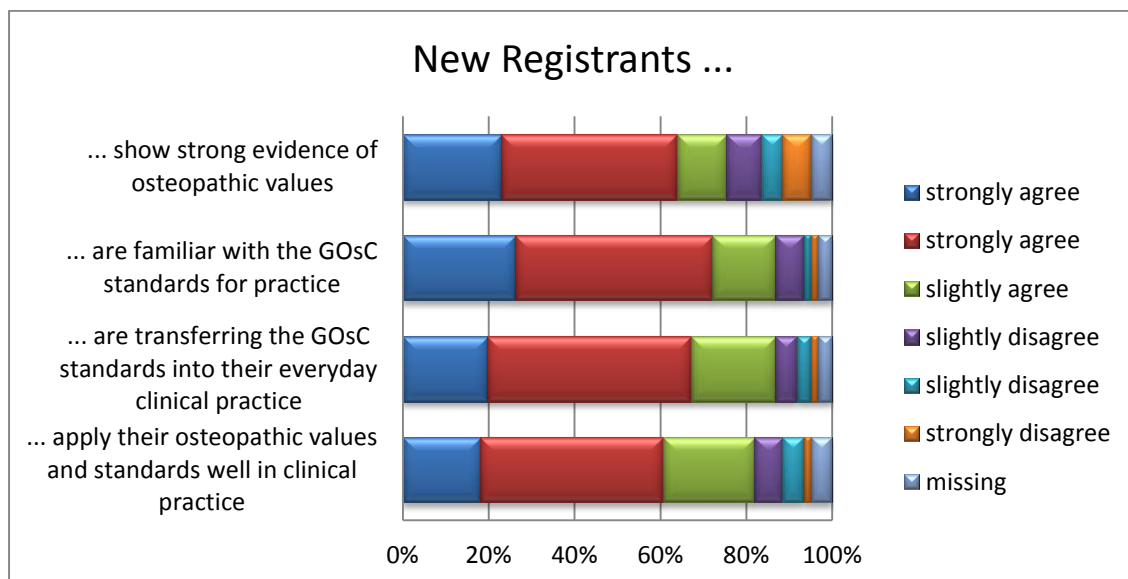


Figure 19: Colleagues’ and Employers’ evaluations of New Registrants’ understanding and application of osteopathic values and GOsC Standards for Practice

7.3.2 New Registrants' perspectives

The New Registrants Survey only mentioned osteopathic values once (in relation to undertaking CPD, see section 7.5). No respondent expanded upon the idea of osteopathic values.

New Registrants answered five questions relating to knowledge and use of GOsC standards for practice. The results are presented in Table 21 and Figure 20. Most respondents (68%) agreed or strongly agreed that the standards for practice were embedded in their osteopathy degree (24% signalling ambivalence by selecting 'slightly agree' or 'slightly disagree'). However, fewer (54%) reported even partial familiarity with the most up to date standards for practice: this is probably because current and proposed standards for practice were in circulation at the time of the New Registrants' Survey and the *Response to the Osteopathic Practice Standards Consultation*³² was published in the same month as the New Registrants' Survey was launched. Just over half the respondents (52%) agreed or strongly agreed that it is easy to apply the standards in practice (39% were ambivalent); but fewer reported using the standards as a baseline for professional practice (46% agreed, 39% ambivalent); or thought knowledge of the standards enhanced their practice (36% agreed, 47% ambivalent).

	I am at least partly or more familiar with the most up-to-date GOsC standards for practice	The standards for practice were embedded in my osteopathy degree	Knowing the standards has enhanced my practice	It is easy to apply the standards in my practice	I use the standards for practice as a baseline for professional practice
strongly agree	11 (9.2)	21 (17.6)	6 (5.0)	7 (5.9)	13 (10.9)
agree	53 (44.5)	60 (50.4)	37 (31.1)	55 (46.2)	42 (35.3)
slightly agree	40 (33.6)	22 (18.5)	38 (31.9)	31 (26.1)	37 (31.1)
slightly disagree	6 (5.0)	6 (5.0)	18 (15.1)	15 (12.6)	9 (7.6)
disagree	6 (5.0)	7 (5.9)	13 (10.9)	7 (5.9)	12 (10.1)
strongly disagree	3 (2.5)	2 (1.7)	6 (5.0)	3 (2.5)	2 (1.7)
missing	0	1 (0.8)	1 (0.8)	1 (0.8)	4 (3.4)
Totals	119	119	119	119	119

Table 21: New Registrants' responses to questions concerning GOsC Standards for Practice

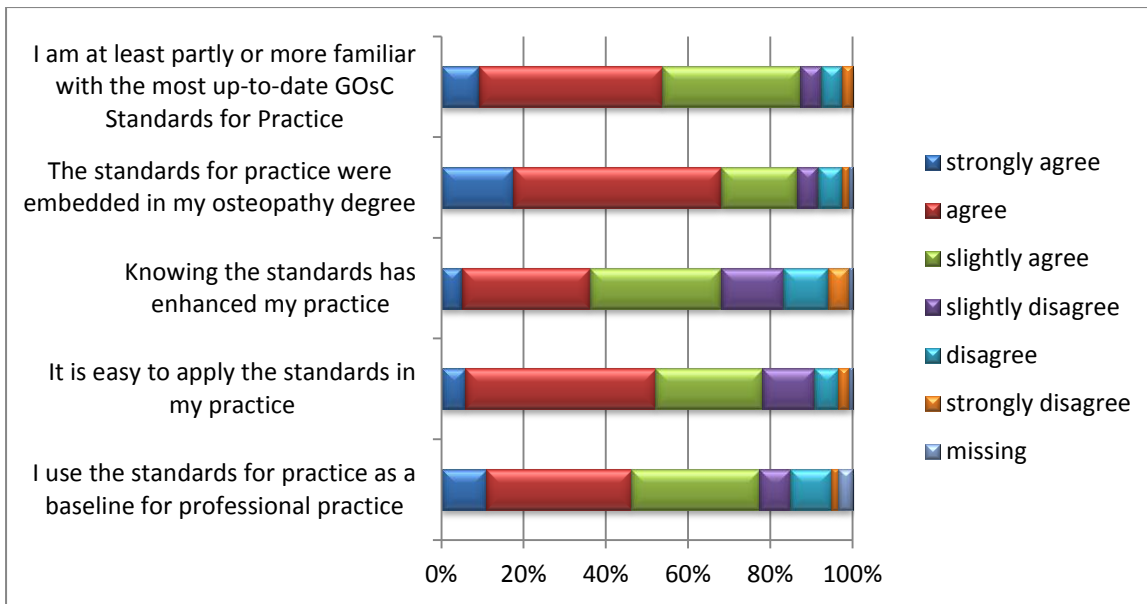


Figure 20: New Registrants' responses to questions concerning GOsC Standards for Practice

The only aspects of standards for practice that were picked out in free text comments by some New Registrants were the linked issues of explaining risks and gaining consent. A small number of New Registrants felt that their meticulous descriptions of potential risks had caused patients unnecessary anxiety and adversely affected the therapeutic relationship. Sometimes patients declined the most effective treatment. These New Registrants were still honing their interpersonal and communication skills (see Chapter 5) and may have behaved a little clumsily; or they may not yet have been fully at ease with patients exercising their right to decline any intervention for any (or no) reason.

7.3.3 Faculty and students' perspectives

Discussions with faculty and final year students about osteopathic values and standards for practice produced interesting narratives that linked to two emergent themes in Chapter 9: Diversity, Variability and Uncertainty and Autonomy and Isolation. Study participants reported that, while there are some common threads, OEIs have developed and prize subtly different values and positions about what osteopathy is as a set of practices, which influences the educational ethos. Participants believed that different OEIs produced graduates with slightly different skill profiles and subtly different orientations to practice. Although we cannot verify these reports, the narratives in these reports appear to be that diversity of ethos and emphasis among OEIs was an important part of OEI's autonomy and the profession's diversity. However, it was recognised that the promotion of different (some would say competing) cultures within osteopathy education, does not support the development of osteopathy as a distinct profession with a common set of values.

There was no spontaneous discussion of any possible uncertainty or variability that might be experienced by patients as a result of OEIs particular approaches to preparation for practice. However, participants did note that diversity was not always attractive to practice principals and we heard on occasion that principals preferred to recruit graduates from an OEI with which they felt familiar: this was often the OEI from which they themselves graduated, or from which respected colleagues graduated. It was thought that this pattern had been replicated within some OEIs, with their own graduates traditionally preferred when faculty were recruited. Unease had grown about the lack of 'cross-over' between OEIs and, in recent years, greater diversity in the osteopathic backgrounds of faculty had been sought by some OEIs to stimulate cross-fertilisation of ideas and guard against fracturing of the profession.

In the context of prized diversity among education providers the GOsC standards for practice were important to ensure that all osteopathy degrees resulted in adequate preparedness to practise. The timing of this study meant that faculty and students were talking about *Standard 2000: standard of proficiency*,³⁰ "S2K", and the associated code of practice.²⁹ From the Faculty perspective, the S2K standards drove learning and assessment, and embedded a sense of professional behaviour in learners from the earliest stages of the programmes. This arose partly due to approval processes for degrees to secure academic and GOsC accreditation, but also because faculty were preoccupied with preparing students for *autonomous* professional practice. For example, one said:

I think about 70% go into isolated practice. So from the minute they graduate, that's it. They may have to make a lot of judgements and difficult decisions on their own. So we, we're quite, we're quite sort of aware of those err issues. I think again with their education, constantly referring to S2K, which is the standard of proficiency they have to meet ..." (Faculty)

Being a professional, over and above being a standard academic student, therefore begins from day one.

Although S2K standards relate to factors such as appropriate environments, perhaps most significance is attached to ethical behaviour and obtaining informed consent prior to clinical intervention and physical assessment. Protection of vulnerable patients is high on the agenda of professional actions, and on the basis of final year student interviews has been embedded fully in curricula. From a more holistic professional perspective, the standards add up to more than the protection of the vulnerable: they apply to ensuing sound practices and safeguarding the reputation of osteopathy in the contexts of patient management, marketing services, limits to practice, relationships with other professions and so on.

The narratives were typified by different levels of understanding and appreciation of various constructs. Firstly, there was a range of views on the GOsC standards. Faculty tended to

speak of the standards as a framework which guided educational delivery and critical thinking to support appropriate professional behaviour, as the following description shows:

“It’s introduced obviously in the first year, all the codes and everything are introduced in the first year and then they’re built on as they progress through the course and there’s a lot of scenarios that is worked with them and they’re giving a lot of scenarios and there’s actually a form of an assessment around this...” (Faculty)

However, students tended to view many of the standards as unwieldy, overly wordy, and not always relevant to practice.¹ On reflection, the focus group moderators did not fully probe the extent to which in-house clinic learning and other placement experiences contribute towards developing an embodied understanding of infusing daily osteopathic practice with the principles encapsulated by the GOsC standards for practice. The most cited standard, which seemed to be the most profound in students’ minds, was the clause around ensuring informed consent from patients. We saw in section 7.3.2 that this was also highlighted by New Registrants.

7.4 Evidence-based practice (EBP)

7.4.1 Faculty and students’ perspectives

Contributions to focus group discussions with faculty and final year students touched on the use and development of osteopathic evidence applied to practice – on the one hand traditionalists and on the other modernists, who understood evidence in differing ways. Traditionalists regarded osteopathic evidence as gained by experience of practice, while modernists regarded it as gained by empirical research. Both groups wished to enhance the profile of osteopathy as a valid alternative to medicine and manual therapies such as physiotherapy and chiropractic. It is not clear whether the coexistence, blending and any possible conflict between these orientations to evidence contributed to uncertainty for students or New Registrants. However it is worth noting here, that in Chapter 10 we will show that the ‘gold standard’ definition of evidence-based *medicine*³³ embraces a several types of evidence and stresses *judicious* use of current best evidence (i.e. exercising professional judgement) in relation to individual patient needs.

The other theme in discussions of EBP was the poor availability of evidence (however defined). Osteopathic evidence was felt to be in particularly short supply. Faculty and students made heavy use of medical and physiotherapy literature and reported that the physiotherapy literature was more useful to guide osteopathic practice. Final year students were keen to see an increase in osteopathic research to support practice. They were also

ⁱ They were referring to S2K³⁰ and *Code of Practice*²⁹ not the newer *Osteopathic Practice Standards*,³¹ which in our view, are clear and succinct.

concerned about access to bibliographic databases after graduation, since they habitually used these to identify relevant resources to enhance their knowledge and support practice. They were also concerned about post-graduation access to books, journals and other learning resources.ⁱⁱ Faculty and students felt that the GOsC had a role in supporting the development of evidence for osteopathic practice and ensuring free or affordable practitioner access to evidence from osteopathy, physiotherapy, medicine and beyond.

7.4.2 New Registrants' perspectives

New Registrants were asked six closed questions about EBP and the results are summarised in Table 22 and Figure 21. Unlike the focus group discussions reported in section 7.4.1, this set of questions did not probe the complexity of respondents' views on the use and development of evidence for clinical practice; so we cannot be sure about the perspectives from which they were answering.

	I understand the concepts of evidence-based practice.	There is an adequate evidence-base for osteopathy practice.	I can access up to date evidence to underpin my osteopathy practice	I am familiar with relevant clinical guidelines to underpin my osteopathy practice	I make use of contemporary research evidence to inform my osteopathy practice	Evidence-based practice is an unrealistic ideal
strongly agree	39 (32.8)	4 (3.4)	4 (3.4)	5 (4.2)	12 (10.1)	11 (9.2)
agree	69 (58.0)	21 (17.6)	21 (17.6)	60 (50.4)	51 (42.9)	18 (15.1)
slightly agree	7 (5.9)	28 (23.5)	46 (38.7)	39 (32.8)	31 (26.1)	29 (24.4)
slightly disagree	0	23 (19.3)	21 (17.6)	9 (7.6)	13 (10.9)	23 (19.3)
disagree	2 (1.7)	27 (22.7)	17 (14.3)	2 (1.7)	7 (5.9)	29 (24.4)
strongly disagree	0	14 (11.8)	7 (5.9)	1 (0.8)	3 (2.5)	6 (5.0)
missing	2 (1.7)	2 (1.7)	3 (2.5)	3 (2.5)	2 (1.7)	3 (2.5)
Totals	119	119	119	119	119	119

Note: numbers in parentheses are percentages

Table 22: New Registrants' responses to closed questions about EBP

ⁱⁱ We did not probe interviewees' awareness that all UK-registered osteopaths enjoy unrestricted access to the content of several research journals via the GOsC **o zone** web site (e.g. Clinical Biomechanics, International Journal of Osteopathic Medicine, Journal of Bodywork and Movement Therapies, Journal of Manipulative and Physiological Therapeutics, Manual Therapy, Medicine and The Spine Journal). Thus we cannot be certain whether students expressing concerns were unaware that this access would become available upon registration, or desired access to different resources.

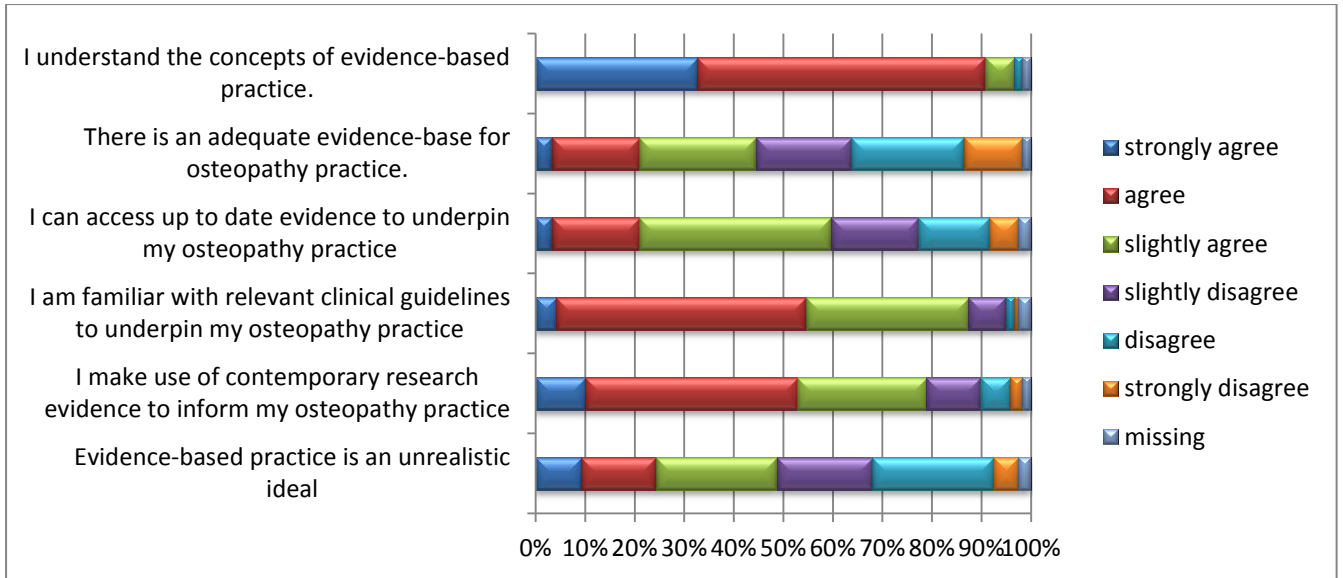


Figure 21: New Registrants' responses to closed questions about EBP

There was strong support for the statement 'I understand the concepts of evidence-based practice' with 91% of respondents selecting 'agree' or 'strongly agree' and only 2% disagreeing. The statement about familiarity with relevant clinical guidelines was also well-supported (55% agreed or strongly agreed). However, echoing student and faculty perspectives (section 7.4.1), there was much less certainty about the adequacy of the evidence-base for osteopathy practice (43% were ambivalent, selecting either 'slightly agree' or 'slightly disagree'). While just over half the respondents (53%) agreed or strongly agreed with the statement 'I make use of contemporary research evidence to inform my osteopathy practice' (which tallies with Colleagues' and Employers' praise for their up to date knowledge, see section 4.5.2); most respondents (56%) were also ambivalent about their ability to access up to date evidence. Thus, use of contemporary evidence may be difficult to sustain in the light of the uncertainty expressed here about access to up to date evidence. Finally, ambivalence was the most common response (44%) to the suggestion that EBP might be an unrealistic ideal.

One respondent described how attending a local CPD group was supporting her ongoing development of EBP, writing:

"I attend a local osteopathic CPD group, which (luckily for me!) is run by someone currently undertaking a Masters in Pain Management. He and some of the others have sharpened my evidence-based practice greatly." (NR)

In the context of EBP, one respondent highlighted a much wider issue: the difference between understanding principles or theoretical knowledge, and being able to bring these alive in the actions of daily practice (and interestingly, he chose the word medicine in preference to practice).

[1] *“Understand the need for evidence based medicine but sometimes felt unable to relate this, and explain to patients, with regards to diagnoses made and treatment plans.” (NR)*

In the following quotation, another New Registrant challenged current conceptions of EBP, perceived to be rooted in a medical model, saying:

“I believe that trying to develop an evidence based osteopathy using the current orthodox, Galenic medical model used in our society is a total waste of time and will not strengthen the position of osteopathy. Current orthodox medicine treats conditions and research focuses on disease while osteopathy and osteopaths treat people and look to enhance body's self healing mechanisms. I know that osteopathy works for many musculoskeletal and non musculoskeletal presentations and patients benefit from it. That is what is the most important!”

However, there were respondents who would have valued greater emphasis on EBP within osteopathy degrees and the focusing of research resources, as the following quotations illustrate:

“Overall I was very satisfied with my education. The biggest area I believe could be improved upon was the development of more evidence based approach from the onset of training.” (NR)

“... opportunities for a practitioner to get into osteopathic research needs to be addressed. I personally would like to conduct research, as I like many osteopaths understand in the need for evidence to support practice and the treatment of an increased number of conditions. However, with little to no opportunities and no financial backing there are limited options to follow up on this. ... Furthermore I think that there needs to be a shift in the type of research conducted. Although I recognise the need for both clinical and survey based research, from the perspective of a practising osteopath I think that the major need is for research to be conducted on providing evidence on the efficacy of osteopathy and osteopathic techniques in clinical situations, as opposed to focusing research on surveys i.e. the public perception of osteopathy for example.” (NR)

One registrant argued that, more widely, evidence for practice may be prized but is not necessarily used:

“We all know that a lot of the evidence we need will never be forthcoming or affordable to the profession, let's face it, and even if we did have it no one in the NHS cares that much, they don't even use research data [example] that would save millions in care costs each year. Rock and hard place.” (NR)

7.4.3 Colleagues and Employers

The Colleagues' and Employers' Survey did not ask a specific question about EBP, but a small number of respondents identified the knowledge and use of evidence to support practice as a clinical strength of New Registrants.

7.5 Reflective practice, self-evaluation and engagement with continuing professional development

7.5.1 New Registrants', Colleagues and Employers' perspectives

Professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. Table 23 and Figure 18 show that the great majority of respondents to the New Registrants' Survey were confident that they could recognise their strengths and weaknesses. (Despite piloting, the accompanying question is ambiguously worded and consequently difficult to interpret.) It is evident from earlier chapters that New Registrants readily identify strengths and areas for development different aspects of their practice (clinical knowledge and skills, Chapter 4; interpersonal and communication skills Chapter 5 and entrepreneurial and business skills, Chapter 6: New Registrants provided a large number and range of examples, which were summarised in these chapters and linked to the cross-cutting theme of Diversity, Variability and Uncertainty (Chapter 9).

	I feel confident in my abilities to recognise my strengths and areas for development in my practice	I feel my training has enabled me to recognise the limitations of my practice and to practise safely
strongly agree	28 (23.5)	40 (33.6)
agree	62 (52.1)	50 (42.0)
slightly agree	16 (13.4)	16 (13.4)
slightly disagree	8 (6.7)	7 (5.9)
disagree	2 (1.7)	4 (3.4)
strongly disagree	1 (0.8)	1 (0.8)
missing	2 (1.7)	1 (0.8)
Totals	119	119

Table 23: New Registrants' responses to questions concerning self-monitoring

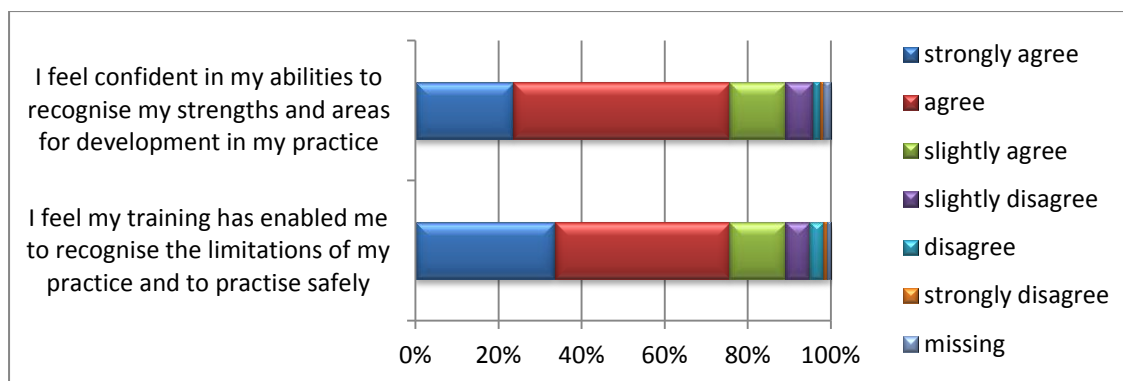


Figure 22: New Registrants' responses to questions concerning self-monitoring

The accuracy of New Registrants' self-evaluations is somewhat difficult to gauge, although the data from Colleagues and Employers highlights variability: both in terms of individual variability in self-awareness, and at aggregate levels across different areas of professional practice. At aggregate levels New Registrants and Employers and Colleagues agreed that New Registrants had a good knowledge base to underpin clinical practice (Chapter 4); were competent in a restricted range of clinical skills (Chapter 4); demonstrated osteopathic values and were conversant with Standards for Practice (Chapter 7); and were unevenly prepared for collaboration with other healthcare professionals (Chapter 5); most communicated reasonably well with patients, although they struggled to set realistic expectations (Chapter 5) and finally, they found the business aspects of practice very challenging (Chapter 6). When, in aggregate, Colleagues and Employers thought New Registrants' self-evaluations were over-optimistic, this related to: the range of their clinical competences (Chapter 4); New Registrants' ability to engage in critical thinking, then convert this to targeted investigations and streamlined treatment plans, including promoting self-help (Chapter 4); the quality of their interpersonal skills and the appreciation of the impact that interpersonal skills have on clinical outcomes and building a patient base (Chapters 5 and 6); unrealistic expectations about their value within group practices and the ease of building and maintaining a successful osteopathic business (Chapter 6).

Professionalism requires that, working hand in hand with reflection leading to realistic self-evaluations, practitioners engage in career-long learning to update, refine and expand their expertise. Colleagues and Employers suggested that attitudes and dispositions are central to this. The following quotations provide two examples:

- *"I chose people who are keen and enthusiastic. You can increase their skill level and give them lots of experience and guidance, but you can't help them if they are lazy or don't want to learn"* (C/E)
- *"I have found that the new registrants have not made the most of having other experienced practitioners around. It has been as if they dare not admit that they*

don't know something - I would much rather have a graduate that recognises their limitations and refers on or involves others.” (C/E)

Regulations for career-long learning which applied during this study demanded that New Registrants complied with CPD requirements, at the latest ten months after joining the professional Register or within 14 months of graduation, whichever is sooner.¹⁸ Study participants usually expressed this as New Registrants being exempt from CPD for the first year after their graduation. Although the division is a little crude, this means that during the period of this study we expected the 2009 cohort to be making a CPD return to the GOsC, but not the 2010 cohort. Mandated engagement with CPD sets minimum expectations and should not preclude wider engagement with CPD. Cross-tabulating and then aggregating answers to separate questions concerning participation in CPD focused on clinical knowledge and skills, interpersonal skills and more general aspects of osteopathic practice, we found that the vast majority of respondents (88% of the 2009 cohort and 84% of the 2010 cohort) had participated in CPD (see Table 24).

Registration year	Participation in CPD		
	Yes	No	Total
2009	50	7	57
2010	49	9	58
Total	99	16	115^a
^a 4 missing responses			

Table 24: Participation in CPD by year of registration

A very wide range of examples was provided when participants elaborated on the answers recorded in Table 24, again drawing attention to diversity (section 9.4). CPD was mainly focused on additional clinical skills, and related underpinning knowledge, to expand participants' repertoire of diagnostic and treatment skills, most often cranial work or acupuncture; some focused on developing their expertise with respect to specific patient groups, most often children; some had focused on business-related CPD, while three had commenced masters courses (chiropractic, medical acupuncture and sports medicine). Several respondents had completed First Aid courses and some noted this as something they felt should have been integral to their osteopathy degree. Self-directed study, attending practice-based CPD and local and regional CPD groups were all popular; reflecting New Registrants concerns about the cost of many CPD opportunities. Nevertheless many had attended short-courses or conferences, or undertaken more substantial programmes of study, sometimes leading to additional qualifications.

One 2010 New Registrant elaborated on her reasons for engaging with CPD from the very beginning of her career:

“Even though we have a 10 month “amnesty” I have undertaken 2 weekends of CPD because I feel that I only know the basics and want to increase my knowledge” (NR)

Although, commenting on the availability of CPD opportunities, another member of the 2010 cohort adopted a strikingly different stance, saying:

“Unknown as I have been exempt I haven't looked” (NR)

One Respondent made an interesting observation and suggestion in relation to New Registrants' initial exemption from CPD requirements, writing:

“CPD requirements are waived for the 1st 9 months of registration after qualifying. Nice gesture but a shame that CPD done during this time (when the osteopath is likely to have the most free time, and insight into areas of knowledge/skill that were lacking from their degree course) will not be counted towards anything. Maybe an EXTENDED CPD period eg. 18 months to do the 1st year's requirements would be better, rather than the current system which encourages postponing CPD to save on the expense.” (NR)

In answers relating to CPD it was common for New Registrants to make positive acknowledgements of mentorship from practice principals and sometimes other experienced colleagues. We will return to mentorship in the next chapter. Some New Registrants also noted that the group practices in which they worked held regular in-house CPD activities.

When New Registrants described the factors that influenced their selection of CPD activities, cost and other practical matters, such as location and timing, were the most frequently mentioned influences, followed by knowledge gaps, improving clinical skills the New Registrant felt to be weak and learning new clinical techniques to better meet patients' needs. Alignment with current patients' concerns and the likelihood of being able to apply learning immediately in practice also influenced CPD decisions. After these concerns, personal interest was a factor. A few respondents mentioned meeting the GOsC CPD requirements. The data also revealed a degree of wariness about selecting good quality CPD: New Registrants reported checking out course leaders, their qualifications, reputations, and for possible conflicts of interest; some also investigated the science and evidence underpinning the topic of the CPD before making a commitment. This wariness, rooted in perceptions of variable quality, links to the emergent cross-cutting theme of Diversity, Variability and Uncertainty (Chapter 9). Figure 23 contains typical comments relating to factors weighed before pursuing a CPD opportunity.

- *“Value for money and quality of course” (NR)*
- *“Can I afford to attend? Can I afford not to attend?” (NR)*
- *“ 1) Cost. 2) How will it benefit my patients? 3) How will it make me a better practitioner?” (NR)*
- *“First considerations are practical ie. where the course is being held, cost of course, date and time of course. Second considerations are the subject matter and the course leader.” (NR)*
- *“does it address weak points? will it integrate into my current practice?” (NR)*
- *“Current skills/knowledge gap. Will the CPD course benefit my treatment considering the demographics of my patient base. Interest in subject matter I like to have a mixture of osteopathic & more general msk health CPD” (NR)*
- *“What extra skills do I need to treat my clients? What new treatment types do I need to acquire so that I have the expertise I want to be able to offer my clients what they need? Usually, all books, courses you choose stem from a problem or skill you've needed after a client exposure.” (NR)*

Figure 23: Examples of factors weighed by New Registrants before undertaking CPD

7.5.2 Faculty and students' perspectives

Within OElS the main activity associated with self-evaluation and commitment to career-long learning was the promotion of reflective practice, although this had a relatively short history at some OElS. Reflective activities included, for example, reflecting on experience in clinic and linking this to Standards for Practice. Developing student's skills of self evaluation was felt to be important, not only to develop ability to reflect on one's own practice, but also to support the identity of osteopathy as more than a vocation that involves some pre-ordained manipulations (which faculty thought was the perspective of some junior students). It was also common for faculty to state that reflection and self-assessment was not something which the students enjoyed and they found it difficult, particularly in the beginning. The focus group extract in Figure 24 appears to support this view. Nevertheless student views were mixed: whilst some students characterised reflective and self assessment curriculum components as irrelevant to becoming a clinician, conversely others found reflection valuable as a method to support critical thinking and self-directed learning. For example one student said:

“I would sort of say that the best part of the course for me has been the sense that, despite the breadth of the subject and the approaches that are here, we've always been encouraged to critically reflect on everything that we've been given”. (FYS)

PAR1: *“The first thing you have to ... after doing a practical exam, the first thing they ask you is, ‘how do you think you did?’ so you’ve always got that ...*

PAR2: *Reflective.*

PAR1: *Reflective, be self-reflective.*

PAR2: *And actually, in clinic, part of the assessment is self-assessment isn’t it.*

PAR1: *Yeah, we have to grade ourselves three times a year.*

PAR3: *Everyone hates doing that.”*

Figure 24: Extract from student focus group; reflection and self-assessment

7.6 Summary

Professionalism is a complex and diffuse concept, which does not stand aside from other aspects of expertise. Consequently we touched on aspects of professionalism in earlier chapters, particularly the emphases on safety and communication with patients within clinical education, preparedness for interprofessional collaboration and preparedness for the interplay between professional behaviours and building a successful osteopathic business. In this chapter we summarised data pertaining to additional aspects of professionalism, viz: osteopathic values, standards for practice, evidence-based practice, engagement with continuing professional development, reflective practice and self-evaluation.

There was no consensus about osteopathic values, rather prized diversity of perspectives which linked to two emergent cross-cutting themes which will be addressed in Chapter 9: firstly, Diversity, Variability and Uncertainty and secondly, Autonomy and Isolation. In the context of slightly different emphases in osteopathy degrees, GOsC Standards for Practice were important to ensure common thresholds for preparedness to practise. From the OEI perspective, the S2K standards drove learning and assessment, and embedded a sense of professional behaviour in learners from the earliest stages of the programmes.

Consideration of evidence-based practice (EBP) prompted discussion of different understandings of the nature of evidence in relation to osteopathic practice and some concern about the role of EBP in enhancing or damaging the profile of osteopathy as a valid alternative to medicine and manual therapies such as physiotherapy and chiropractic. Students and New registrants were confident about their understanding of EBP, but highlighted a gap between understanding and the ability to enact EBP in daily practice. They and faculty highlighted the poor availability of evidence (however defined). This had two components: firstly, osteopathic evidence was felt to be in particularly short supply.

Secondly, students and New Registrants were concerned about rather limited free or affordable access to bibliographic databases and journals, once they graduated.

Professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. The great majority of respondents to the New Registrants' Survey were confident that they could recognise their strengths and weaknesses, although data from the Colleagues' and Employers' survey highlighted variability. Within OEs the main activity associated with self-evaluation and commitment to career-long learning was the promotion of reflective practice, although this had a relatively short history at some OEs. This study found high rates of participation in CPD, even among those in their first post-degree year and, therefore, exempt from GOsC CPD requirements.

Chapter 8 Supporting osteopathy graduates' transitions into practice

8.1 Précis

This chapter explores accounts of transitions into practice and identifies mechanisms for supporting New Registrants. Firstly, good quality clinic and placement learning during osteopathy degrees is a vital mechanism for supporting graduates' transitions into practice. We described perceptions of current provision in Chapter 4 and highlighted the importance of role modelling by clinic tutors in Chapter 5. In this chapter we add a summary of Colleagues' and Employers' priorities for strengthening clinical education in osteopathy degrees.

Once in practice, mentorship was the most commonly practised form of support. Arrangements varied widely and were often ad hoc. The focus tended to lie with immediate support needs, rather than systematic development of New Registrants' practice, and with clinical matters much more than practice management or business development. New Registrants sought and received mentorship from many sources, most often practice principals, immediate colleagues and former OEI tutors. A lower proportion of New Registrants who practised alone received mentorship. In principle, nearly all study participants from all stakeholder groups supported more extensive and more formal mentorship for New Registrants, but resource requirements were thought to be insurmountable. Some opposition was related to safeguarding autonomy.

Discussion of mentorship led into consideration of a period of conditional registration or a structured foundation period. There was support and opposition to both ideas. Support focused on reducing isolation and providing help and mentorship, particularly to borderline New Registrants. Opposition focused on resource demands and concerns about loss of autonomy, excessive monitoring and the possibility of exploitation.

Early engagement with CPD also supported New Registrants' transitions into practice: firstly, plugging perceived gaps in skills or knowledge; secondly, expanding the New Registrants' knowledge and repertoire of techniques; thirdly, and linked to both plugging gaps and extending expertise, early engagement with CPD built New Registrants' confidence in their professional practice. Building confidence and expanding expertise were also thought to be outcomes of working in group practices and multidisciplinary settings, particularly busy ones. These environments were felt to be better than lone practice for New Registrants.

Ongoing support from New Registrants' former OEIs and faculty was noted. Many New Registrants were keen to see an expansion of this, including ongoing access to physical and electronic library resources.

8.2 Introduction

There are many ways to support novice practitioners' transitions from initial training into qualified practice. In this study, without necessarily naming them as such, participants reported their views on six mechanisms. Each of the mechanisms identified by study participants will be described from their perspectives in this chapter and then discussed in relation to other professions and the wider literature in Chapter 10.

Clinic and placement learning during osteopathy degrees lays the foundations for competent professional practice and, beyond safe execution of correctly selected interventions, has the potential to develop realistic expectations and enhance interpersonal skills. Perceptions of current provision were described in Chapter 4 and the importance of role modelling by clinic tutors was highlighted in Chapter 5. Section 8.3 summarises Colleagues and Employers priorities for strengthening clinical education in osteopathy degrees.

After graduation, mentorship was the most widely practised and extensively discussed mechanism for supporting New Registrants (section 8.4). Other mechanisms for supporting transitions to practice that were identified in the data collected for this study were: conditional registration or a supported foundation period (section 8.5); early engagement with CPD (section 8.6), working in group practices and multidisciplinary environments (section 8.7) and ongoing support from OEs and faculty (section 8.8).

8.3 Strengthening clinical education in osteopathy degrees

In earlier chapters we suggested that clinic and placement learning is a vital, but perhaps not fully developed, part of students' preparation for practice. Perceptions of current provision were described in Chapter 4, mainly from the perspectives of faculty and final year students in section 4.6. We saw that clinical education and assessment was directed towards ensuring safe autonomous practice. Consequently, it focused primarily on clinical skills and fulfilling the requirements of GOS Standards for Practice. Role modelling by clinic tutors and the potential for clinic and placement learning to enhance interpersonal skills was highlighted in Chapter 5, while Chapters 6 and 7 touched upon the role that clinic education could potentially have in developing patient management skills, providing realistic expectations and supporting professionalism. A small number of New Registrants also drew attention to the importance of gaining sufficient and sufficiently wide clinical experience with an appropriate range of patients (Figure 25). However, the particular experience of a shortage of student clinic patients was not widely reported.

- *“The demographic of patients in college clinic does not match the normal demographic in practice. It was dominated by geriatric patients with multi-factorial complaints and a poor prognosis. The geriatric population meant that manipulative skills could not be practised as often as desired, leading to an inability to manipulate after graduation. There is a gap between college clinical skills taught and the real world. Often you are practising techniques on healthy bodies and you just don't get the point of the technique.” (NR)*
- *“the college I attended did not have sufficient patients at its student clinic so that sufficient experience in common conditions, let alone the more obscure, was lacking and that meant a lack of confidence on graduating. However the principles of osteopathic practice were well taught and that got me through.” (NR)*

Figure 25: New Registrants' concerns about practising clinical skills

Respondents to the Colleagues' and Employers' survey made a wide range of suggestions about ways in which pre-qualification clinical education could be strengthened to ease graduates' transitions into practice: many of these centred on perceived benefits of increasing the proportion of practice learning conducted outside in-house OEI clinics. Colleagues and Employers also stressed patient management and teamwork. Typical comments are included in Figure 26 (on page 122). Some of the comments link back to concerns reported in chapters 5 and 6 that New Registrants have unrealistic expectations.

8.4 Mentorship

Some study participants spoke of mentorship and supervision without clearly distinguishing between these terms. We cannot be certain whether supervision meant a relationship where an experienced practitioner took responsibility for overseeing or assessing the quality of a New Registrants' work (as might be the case for OEI clinic tutors supervising students' practice); while mentorship meant a more dialogic relationship to support New Registrants' practice development, without overtones of assessment or taking responsibility for the New Registrants' clinical practice. Mostly it seemed that way, but some study participants appeared to use the terms differently or interchangeably. In this chapter we will take mentorship to be a process focused on promoting development of the mentee's professional practice (and possibly the mentor's practice too), without overtones of responsibility lying predominantly with the mentor. However, in quotations we will retain the terms selected by the study participants.

The most striking features of the mentorship arrangements described by study participants was their diversity and lack of structure, once again linking to the emergent cross-cutting theme of Diversity, Variability and Uncertainty (Chapter 9). In most cases, no formal contract (or even informally negotiated contract) guided expectations and defined responsibilities of mentors and mentees. Arrangements tended to be informal and ad hoc,

resulting in variability and uncertainty. There was substantial variation in the degree to which mentors were proactive and systematic in their mentorship.

Comments relating to section 8.3, Strengthening clinical education in osteopathy degrees

- *“More clinic hours and more clinic hours in a real practice.” (C/E)*
- *“More shadowing or work experience outside of clinic in training schools.” (C/E)*
- *“Practice visits throughout their degree course, perhaps some sort of mentoring programme from an established practice.” (C/E)*
- *“On the last year of training I believe that a few hours a month should be dedicated in being an apprentice like in most practical jobs. Observing first and practising with a mentor (experienced osteopath) will help their skills. It is important to learn and get feedback in the clinical setting at the school but it is as important to see where their skills should be aimed at. What they have to work towards in becoming competent osteopaths.” (C/E)*
- *“Students or registrants could shadow working osteopaths for 1-2 weeks to understand what they will need to do. Students could do an internship or placement in their final year. They need to understand basic business skills such as being early/ on time for work and appointments. They need to be aware of working in a team, the importance of communication skills and also the importance of respect i.e. keeping the work and rest places tidy for the next person, or providing feedback to managers so that essential routine maintenance can be carried out (ie clock needs fixing, plinth hydraulics need repair). They need to realise that even if they are employed essentially they are working as self-employed individuals and are responsible for their own time-keeping and for managing their list of patients. Also, that work space is shared with team-mates.” (C/E)*
- *“Better knowledge of patient management in school clinics eg. giving patients an indication of how quickly they can be expected to respond and with how many treatments, what is the value of ongoing treatment,” (C/E)*
- *“In college it would be better if they were given a realistic view of what life is really like in practice and how to deal with people who are paying for their expertise.” (C/E)*
- *“Please teach them teamwork and business skills in their final year! Also, please teach them about interpersonal and communication skills and the importance of professionalism.” (C/E)*

Figure 26: Colleagues' and Employers' suggestions for strengthening pre-qualification clinical education

8.4.1 New Registrants' perspectives

8.4.1.1 Experiences of mentorship

Since qualification, most New Registrants (68%, Table 25) had received mentorship or less formal support from a more experienced osteopath and nearly all these respondents provided examples. On the other hand 22 New Registrants (19%, Table 25) had sought mentorship or less formal support and found it unavailable. Table 26 cross-tabulates responses to the two questions posed in Table 25 and reveals that 23 respondents (19%)

neither sought nor received mentorship; while 11 (9%) sought more mentorship than they received.

	Since qualification have you received mentorship or less formal support from a more experienced osteopath?	Have you sought mentorship or less formal support and found it unavailable?
	Frequency (%)	Frequency (%)
Yes	81 (68.1)	22 (18.5)
No	35 (29.4)	87 (73.1)
Missing	3 (2.5)	10 (8.4)
Totals	119	119

Table 25: Incidence of mentorship or less formal support

		Received mentorship?		Totals
		Yes	No	
Sought but did not receive mentorship	Yes	11	11	22
	No	63	23	86
Totals		74	34	108 ^a
^a 11 missing cases				

Table 26: cross-tabulation of responses in previous table

The main source of mentorship was the New Registrant's practice principal: some helped when asked and others were more proactive, for example some principals encouraged the New Registrant to observe their practice, offered unsolicited advice and taught the New Registrant new techniques. New Registrants who felt well supported by their principal or colleagues often highlighted that they felt theirs was an unusually good situation; they felt others received much less support. New Registrants working in larger practices were likely to receive informal advice from colleagues in addition to mentorship from the principal; some also participated in in-house CPD. Arrangements and levels of engagement were very variable: Figure 27 (overleaf) contains a range of New Registrants' comments on levels of mentorship from principals and other colleagues, while Figure 28 (on page 125) contains comments which illustrate different foci and dynamics within workplace mentorship. It is worth noting that none of these New Registrants' comments relate to mentorship for practice management or business development: if this type of mentorship was provided by principals and colleagues, it did not spring readily to mind when comments were being written. Important themes within New Registrants' comments on mentorship include: readily available help when unsure or when things are not going well, sharing ideas and increasing knowledge, refining thoughts through discussion (often expressed as 'sounding board' or 'bouncing ideas off') and preserving fragile confidence.

- *“My principal mentors me continuously and I have a career plan with him. This is unusual but highly valuable.”* (NR)
- *“I have worked under a Principal very open to observing his practice, discussion of what he is doing, which showed me a very osteopathic approach to diagnosis and treatment, and a very varied selection of patients and problems. However I was not comfortable to discuss any of my specific issues - he was not interested. Luckily I have had informal chats with other osteopaths that I treat alongside at another practice.”* (NR)
- *“2 out of the 3 clinics I work in have been very positive in sharing their knowledge, experience, providing advice and 2nd opinion whenever I have needed it.”* (NR)
- *“The senior practitioner has been very supportive. I’m not sure that other graduates necessarily have the same support”* (NR)
- *“I get support (when asked for) from my principal osteopath. e.g. If I’m struggling with a technique he may show me how to do it, or we will discuss difficult cases!”* (NR)
- *“Occasional input from busy clinic owner”* (NR)
- *“I think mentorship is very important (especially the ability to discuss patients/case histories) but generally found that principals are too busy to spend time on this”* (NR)
- *“One of the things I have found difficult in the transition into practice is some of the principals I have worked for have been very distant and not really available for assistance when needed.”* (NR)
- *“I have just started with a principal and hope to receive some mentoring.”* (NR)

Figure 27: New Registrants’ reports of varying levels of engagement between workplace mentors and mentees

While principals’ mentorship was valued, there were occasions when New Registrants sought mentorship outwith this power relationship; as one respondent put it:

“Some form of mentoring to discuss problems, achievements with someone neutral. My principal has been very supportive but at times you don't want to discuss all your worries with her!” (NR)

In the following paragraphs we will see that New Registrants obtained mentorship from a variety of sources outside their workplaces. Nevertheless workplace mentorship was very important: a higher proportion of sole traders (37%) did not receive any mentorship, compared with New Registrants who were self-employed in a group practice (28%) or, in particular, associates employed in a group practice (17%). However, these differences were not statistically significant ($F=1.317$, $2df$, $p=0.272$).

- *“Able to discuss patients with principal osteopath” (NR)*
- *“My clinical director has been supportive to discuss any cases I may feel less confident in managing, helping to advise or refer the patient on if necessary” (NR)*
- *“discussion with principals and colleagues when unsure of how to proceed with a patient” (NR)*
- *“Regular meetings with the principal osteopath to discuss patient cases centred on improving working diagnoses, identifying common lesion patterns, improving treatment approaches and greater biomechanical understanding.” (NR)*
- *[mentorship] “with principals in two practices, including observation sessions and feedback. Not organised CPD courses but very informative on an individual scale and tailored for my strengths and weaknesses as and when they arose. Subjects included - managing patient expectations, treating the hip, communicating effectively, spondylosis of the neck, etc” (NR)*
- *“assistance on techniques or discussion of patients very occasionally” (NR)*
- *Regular discussions of books and journal articles with my boss” (NR)*
- *“Working as an associate in a practice with other osteopaths and having regular CPD meetings.” (NR)*
- *“Local osteopath and also a principal to bounce ideas off” (NR)*
- *“I have worked alongside experienced osteopaths and they have shared their knowledge and skills with me on different occasions.” (NR)*
- *“The people I have found most supportive are those that qualified a few years ahead of me so still remember what it was like and can be very helpful.” (NR)*
- *“I feel I would benefit greatly from being able to discuss certain cases with a more experienced osteopath. Firstly, I have gone through periods of feeling as though I am 'drifting' away from being clinically competent in my examination and diagnoses, leading to a fear I am missing more serious pathologies. Secondly, I feel reassurance that you have done the correct, justifiable, diagnoses and treatment with the information available when a patient either does not progress or gets worse. Thirdly, discussion of all the 'little' things that crop up in practice you just are not expecting or prepared for would be invaluable, clinical and business wise. No one but an osteopath can provide this support, the way we view the patient, use palpation and form treatment plans leads to unique perspectives on things.” (NR)*
- See also comments in Figure 27

Figure 28: Examples of New Registrants’ comments on the foci and dynamics of workplace mentorship.

After principals, the most common source of mentorship was faculty from the New Registrant’s former OEI. Several New Registrants reported that former tutors were willing to discuss clinical cases and more general aspects of osteopathic practice by telephone and email. New Registrants most often turned to former tutors for assistance with *“tricky cases”* or *“difficult patients”*. In section 8.8 we will see that some faculty also continued to provide clinical technique tuition. Some tutors were very proactive in encouraging their former students to seek help, if required; one respondent explained:

“Tutors have provided mobile phone numbers in case of need - I haven't used them as yet!” (NR)

One respondent had already become a part-time clinic tutor at an OEI and faculty colleagues provided informal mentorship.

Some New Registrants received informal mentorship or support when they met up with other osteopaths working nearby, although one respondent suggested there were “*cliques*” within practising osteopaths, based on where they trained. Consequently local support may have been dependent on whether local practitioners felt an educational affinity with the New Registrant (this links to the cross-cutting theme of Autonomy and Isolation, Chapter 9). A small number of respondents felt that local osteopaths had been unwilling to offer mentorship or less formal support due to the inevitable business competition between neighbouring osteopaths. As one respondent put it:

“Being a sole practitioner, one is in competition with any potential local mentor”
(NR)

However, one New Registrant reported a happier experience, which was dependent on ‘having guts’:

“Osteopaths are quite happy to help each other, you just have to have the guts to introduce yourself to the ones in your area and then ask them questions.” (NR)

As we noted in section 7.5.1, a high proportion of New Registrants participated in CPD courses. Some of these courses contained an identifiable mentorship element, which was considered beneficial.

For some New Registrants, osteopaths within their family and wider social networks were a source of mentorship or informal support, as one respondent described:

“Because I was asked to join a practice I have had a small amount of support, where my [OEI] colleagues have set up on their own they have none, so we tend to chat to each other every so often to see how we are doing and give advice if we can.” (NR)

Nearly all comments related to osteopathic mentorship, focused on clinical issues and patient management, but a small number of respondents had made use of business mentors who were not osteopaths.

The main characteristics of mentorship that are visible in New Registrants’ examples, were its focused and tailored nature, but tendency to be ad hoc and mainly dependent on New Registrants asking for help. Such mentorship quickly met immediate support needs, as is indicated by the following quotations (see also comments in Figure 27 and Figure 28):

- *“50 mins fantastic - more out of it than 5 hours on course.”* (NR)
- *“Observations in practice, double handed treatments of patients I am not having success with.”* (NR)
- *“case discussion if treatment did not solve the problem quickly enough”* (NR)

The data contained far fewer examples of regular, systematic mentorship that was designed to take a more holistic and longer-term view of the New Registrants’ wider professional practice and development needs.

8.4.1.2 Imagining the future of mentorship

New Registrants suggested that a more formal mentorship system would be beneficial and stressed the importance of mentors receiving training and being up to date in their own practice. Most appeared to imagine one-to-one mentoring (face-to-face, telephone, Internet calls or email), while others clearly pictured group mentorship (in person or using Internet discussion applications). Some respondents suggested that OEI faculty were better placed to provide mentorship than principals or other experienced osteopaths in private practice. A few respondents supported voluntary mentorship arrangements but were opposed to mandatory participation in mentorship: their opposition was linked to resource concerns and to valuing autonomy (see Chapter 9). Another small group thought that no changes were required to current mentorship practices, since help was available to those who asked. A very small group feared that greater formalisation of mentorship could open the door to abuses of power by mentors. The GOsC and the BOA were thought to have roles in promoting good quality mentorship. Figure 29 contains some comments from New Registrants who had reservations about expanding and formalising mentorship, while Figure 30 contains a selection of quotations from New Registrants who were more enthusiastic.

- *“I feel that support is available to those who seek it. As ever you have to ask. I don't think however that this should be formalised in any way.”* (NR)
- *“I feel that for some this would be good while others might not need it, just depends on the background”* (NR)
- *“Any osteopath offering mentorship should do so under similar duty of care that they are obligated to provide to patients.”* (NR)

Figure 29: Comments from New Registrants with reservations about expanding and formalising mentorship

- *“A more formal system would be good. There is a big jump from student to practising osteopath”* (NR)
- *“I think a formal scheme should be introduced, I know I have been able to access some help, but I know many who can't.”* (NR)
- *“Should be mandatory if possible. Mentors may need training, but I think both sides get something out of the relationship so hopefully worth it.”* (NR)
- *“I feel that mentorship would be hugely beneficial to newly graduated osteopaths and the profession as a whole, to the extent that I strongly believe a formal system should be set up to cater for this service, either in the form of 'pre-registration' year(s) or an optional "pass-plus" type scheme.”* (NR)
- *“I feel it would be helpful to have a more structured mentorship programme for recent osteopathic graduates, particularly when jobs are scarce and one might face a fairly long period with no or little work”* (NR)

Table continues overleaf ...

- *“support in an acute/busy clinical setting would be ideal where a wide array of medical conditions can be seen (similar to the PRHO/SHOs in hospitals)” (NR)*
- *“I think that this is one of the most important challenges of the profession. As if you work alone in practice help and advice is not easily accessible.” (NR)*
- *“Very quickly my confidence grew as patients came back better but it would have been nice to have some formal mentoring in place to help me through the first few months - and even now as I know I still have a lot of learn and there are many challenges on a day to day basis.” (NR)*
- *“I think in the first year, we should have a mentor linked to the institute where we trained, someone to help ease into practise, and to be there when you just need a bit of advice or information or moral support. Sometimes in the training your confidence can take a serious blow and it’s hard to trust your own skills after.” (NR)*
- *“If I had not undertaken a post-graduate diploma I would have missed a mentorship and support arrangement. However, unless it’s associated with an education establishment, I think it would be difficult to find in private practice as most established osteopaths feel threatened by newly graduated osteopaths.” (NR)*
- *“I think mentorship is very important as it allows a smooth transition from the protected world of the school / knowledge to the competitive business / quick clinical skills. School should organise an informal mode of meetings / video conferences, and all possible to help new entrants to keep the faith and not go back to another job.” (NR)*
- *“I believe that first year graduates should attend a regular mentoring session where groups can share their experiences throughout the first year and discuss what they did about it with experienced, neutral osteopaths on hand to give their perspective. The realities of private practice, including patient management, communication and how to deal with clinical failure should be properly coached, not just mentioned in osteopathic magazines.” (NR)*
- *“Perhaps an online forum for new registrants and potential mentors to tele-mentor if a local mentor is not available” (NR)*
- *“Possible enforced number of hours of meeting/observation of a mentor” (NR)*
- *“GOsC and BOA could remind members of the importance of mentoring recent graduates” (NR)*

Figure 30: A selection of New Registrants' thoughts on expanding mentorship

8.4.2 Colleagues' and employers' perspectives

8.4.2.1 Experiences of mentorship

Most (82%) of the respondents to the Colleagues' and Employers' Survey mentored New Registrants. Their experiences of mentorship confirmed the variability of engagement between mentors and mentees that was reported by New Registrants (Figure 27), as illustrated by the quotations in Figure 31, which range from close supervision to total isolation. Some respondents thought it was important for New Registrants to be proactive and ask for help; some also mentioning self-assessment, reflective practice and commitment to improvement, which links to aspects of professionalism (Chapter 7). Another called for *“Dedicated mentoring. Not absent landlording”* (C/E).

- *“I spend between 4 - 5 hours working with every new graduate who joins me for at least 3 months - usually 6 months.” (C/E)*
- *“They both work with other colleagues and myself - they are never working alone.” (C/E)*
- *“We support them extensively in their first year” (C/E)*
- *“we keep an eye on them working alongside senior colleagues with regular clinical meetings to discuss their development” (C/E)*
- *“It is readily available if they are willing to ask for help from any of the existing practising osteopaths. Within the practice we have a monthly team meeting. This includes 2 hours of CPD. Frequently this includes a case study and the team are encouraged to discuss any difficult cases for second opinions. There is on-going support available through all osteopaths at the practice generally and specifically when there is a problem they can speak to any of the osteopaths; or to the principal osteopath who has 30 years experience.” (C/E)*
- *“I think there is extensive support there but you have to have the ability to ask for help and reflect on areas of weakness and look to improve them.” (C/E)*
- *“New Registrants can get overwhelmed with the time it takes to build their own Patient base. In such cases Observing Senior Colleagues, whilst waiting for new patients is very helpful.” (C/E)*
- *“It's hit and miss. I choose to mentor but didn't receive it myself and it's just luck if they end up somewhere where the lead osteo takes that responsibility” (C/E)*
- *“limited to within clinic situation I am trying to do more workshops but that is more workload on myself when I was needing someone to help take the strain of myself” (C/E)*
- *“Limited supervision, I offer this as part of their ‘package’” (C/E)*
- *“As far as I am aware most practices largely leave new graduates to get on with it unless they shout for help.” (C/E)*
- *“Sadly little at the moment - our new registrant is required to work alone most of the time, running her own list, with little access to practical help or discussion due to the days she works and the busy condition of the practice - she is not there on the day we have practice meetings either, through no fault of her own.” (C/E)*
- *“Very little support in my experience in spite of the support promised little is delivered in practice.” (C/E)*
- *“Very little access to supervision or mentorship” (C/E)*
- *“I don't know, they need support, but they also need to be competent, and a busy practice should not be expected to train people who are already qualified” (C/E)*

Figure 31: Colleagues’ and Employers’ reports of varying levels of engagement between workplace mentors and mentees

8.4.2.2 Imagining the future of mentorship

Many respondents felt that mentorship from experienced practitioners was an important part of supporting New Registrants’ transitions to practice and should be more formally recognised (several suggested that CPD credit would be appropriate and some drew attention to mentors’ own needs for training and support). The quotations in Figure 32 illustrate these views. However, there was some opposition to extending and formalising mentorship, as the following quotations show:

“It is my strong belief that either students are competent to qualify or not, that is what the RQ and FCCA is for. There is no middle ground here, they should be allowed to practice as they wish without further interference from GOsC.” (C/E)

And, closer to occupying the middle ground,

“They need to get on with the job whilst having someone competent & experienced looking over their shoulder.” (C/E)

- *“Formalised mentoring scheme - this could be linked to a 'mentoring contract' with a more experienced practitioner for whom CPD credit could be earned by fulfilling their responsibilities. Could also make use of the (hitherto unused) 'Conditional Registration' category provided for in the Osteopaths Act. I believe this could be effective by face to face, telephone and electronic means, even for practitioners in remote areas, and in sole practice if carefully developed by involving interested practitioners 'in the field' (rather than OEs, who, by their nature, have an institution-based mindset.” (C/E)*
- *“I am influenced by my personal experiences after graduating where principals worked to provided absolutely no support. I think it is essential for all of us who graduate to gain time to consolidate our skills in a clinical setting with an experienced osteopath with management and clinical skills. Experienced osteopaths would need an incentive and recognition from the GOsC such as allowing some of the support to be counted as CPD.” (C/E)*
- *“I'd like to see mentoring for new graduates. Someone they can phone and talk problems over with.” (C/E)*
- *“Supervisor reporting mandatory for first year, practical help with new patient analyses - better support forums among new registrants from different colleges.” (C/E)*
- *“Support tutoring and mentoring from GOsC for new graduates and those that employ/ support them” (C/E)*
- *“They should have a compulsory 6-12 months in an existing practice with a mentor.” (C/E)*
- *“They all need supervision in my opinion. Support needs to be put in place for experienced and established osteopaths to provide that support. It is very costly - but, as principal osteopath I consider it essential to develop my knowledge & understanding of the osteopaths who work with me so that I can see what they need to flourish as osteopaths, to provide the standard of care that I expect for my patients and to develop a team relationship. New graduates should be aware that in the early days they are developing their skills at the risk of the osteopathic practice which they join. Many graduates think they 'know it all' they are now qualified and they don't want or need any help. Undergraduate institutions do their graduates a disservice in promoting that attitude. It would be more appropriate to actively encourage the new graduates to seek supervision in early practice - but also to accept that this comes with a price. Firstly a commitment to stay with the practice where supervision is given for at least 5 years. This should be the norm. In reality a new graduate begins to be really useful in a clinic only after a minimum of 2 years. This is the stage at which they often think it's OK to leave - or even after 1 year! Secondly, new graduates expect a higher level of remuneration than is appropriate when support is being given. I often meet graduates who have been given the expectation of greater remuneration than is appropriate. Another area of consideration is the new graduate's attitude to the management tasks that are essential to running a clinic and willingness to contribute to the reception, business, promotion and patient service aspects of clinical practice. The undergraduate schools do their graduates a disservice if they engender attitudes that do not take these factors into account.” (C/E)*

Figure 32: Examples of Colleagues' and Employers' views on more formal recognition of mentorship

8.4.3 Faculty and students perspectives

Final Year students regarded mentorship as highly desirable, but not necessarily readily available, as the following quotation illustrates:

“But I think what osteopathy lacks to some extent is some form of mentoring after qualifying. Um, I mean a lot of us might go in as associates to practise, but we’re very much alone and often a principal in a practice he will not ... that’s from what I’ve heard, that when you go out into practice you get no support, you might be completely on your own”. (FYS)

Faculty and students almost universally saw mentorship as a good thing, but there were contrasting views on how it should be developed and managed. There was concern that both OEs and practising osteopaths would struggle to provide the volume of support necessary if this became a requirement (part of a supported foundation period, which we will discuss in the next section). Discussions highlighted the need to clarify mentorship requirements, mentor support needs, mentors’ remuneration or other recognition (such as CPD points) and the need to monitor the quality of mentorship, as the focus group extract in Figure 33 illustrates.

PAR2	<i>“But one ... one way that, you know, I think has been spoken about at meetings that I’ve gone at, is the, you know, concept of having kind of mentor practice ... for the first year or whatever. Err, which personally I think would be a really good idea erm ...</i>
PAR3:	<i>But how do you choose the mentors?</i>
PAR2:	<i>Well, I mean there are all sorts of technicalities about how you ... how you use the mentors, how you choose the mentors, and who’s going to pay for it”.</i>

Figure 33: Focus group extract of faculty discussing more formal mentorship

It was recognised that any strategic development of the profession’s use of mentorship would require partnership working between the GOsC, BOA, OEs and the community of practising osteopaths. Generally, there was support in principle for more extensive and more formal mentorship, but resource requirements (financial and human) were thought to be insurmountable, particularly in the current economic climate. Those who were less supportive of any such development argued ‘if it ain’t broke don’t fix it’. The creation of local networks and hub and spoke approaches as informal processes were the favoured options: on cost grounds and due to their voluntary nature (which links to Autonomy, see Chapter 9). One student remarked:

“Exactly, a body of osteopaths who would happily advise new graduates if they’d had problems, like somebody that you could call. Somebody that you could just talk and debate certain patients over, things that you’re not quite sure about, have that body of qualified osteopaths who are quite confident in what they’re doing, very, um, experienced who would happily chat.” (FYS)

The overriding themes were of choice and cost effectiveness. The student focus group extract in Figure 34 shows that the issue of choice was multifaceted, for these students encompassing autonomy and an appreciation that the quality of mentorship hinges on the quality of the human relationship.

PAR1 *"I don't know. At a certain point we've got to realise we're adults. Um, it's got to be informal hasn't it?"*

PAR2: *Informal, yeah.*

PAR1: *Because you could get people that resent it otherwise I think.*

PAR2: *I think if it's formalised you've got to find someone you're comfortable with as well. So if you're like okay, you're partnered up with them and you don't get on that's no good to anyone. I guess that's why actually we all feel that if we were out there and we had a nightmare situation we could ring up the college or ring up a tutor, um, that's probably as good as it gets maybe".*

Figure 34: Student focus group extract discussing mentorship

8.5 Conditional registration or supported foundation period

As the first quotation in Figure 32 shows, extending and formalising mentorship for New Registrants could be considered one step towards a period of conditional registration, which many people called a 'pre-registration year' although we did not probe why one year was the duration that was imagined. For example:

"Some post graduate system like the pharmacists, who have to do a pre-registration year as a graduate before fully qualified." (C/E)

Conditional registration carries the implication of assessment preceding full registration, while a supported foundation period would formalise and extend current mentorship practices (section 8.4) and possibly include other elements.

Conditional or provisional registration was an idea that was supported and opposed with almost equally strong feelings. Supporters highlighted the benefits of providing all New Registrants with ongoing support and help when needed and its particular value for a minority of New Registrants who might be considered borderline (just above the minimum standards to graduate), or in some other way were predicted to need help and guidance; as the following quotation illustrates.

"Ideally, if I had a wish list, I would very much like a pre-registration year for osteopathic undergraduate students because if you look at a cohort of say [number range], I think the vast majority do come out with no problems at all, but there are some who I would say, you think they're competent but it would be in your best interest to join an existing practice so you can call upon experienced practitioner for help and support". (Faculty)

However, opponents argued that qualification is absolute and that if graduates have been prepared for practice well enough they should be ready to practise independently without

perceived surveillance. Seeking help should be a choice, not a requirement (another reference to Autonomy, to which we will return in Chapter 9). If current graduates were not considered adequately prepared, opponents of conditional registration directed attention to reviewing degree programmes.

“If the GOsC considers they need more knowledge then that should be built into the courses. They should still have a cut-off point where they either are or not qualified. Keep draping them around for a year afterwards or 6 months afterwards has no value at all. And so you’ve got, I think if this process means that certain things need to be incorporated into the degree, so for instance business studies is currently not really a part of our ... ” (Faculty)

A structured and supported foundation period, without conditional registration and associated assessment, was also supported as a means to reduce isolation and provide mentorship, as the quotations in Figure 35 illustrate. However some study participants had reservations, warning:

- *“Any structured system risks under or over provision.”* (C/E)
- *“I know that some other professions, [profession] for instance, registrants are used as virtual slaves for their post grad year, working for employers who pay very little and give little or nothing in terms of useful support but force students to work as cash cows for established [profession] practices.”* (C/E)

Indeed, there were concerns among all stakeholder groups that a minority of osteopathic principals tended to exploit rather than support New Registrants and that any movement towards conditional registration or a foundation period could exacerbate this.

- *“There’s some sort of period where internship or [unclear] and we don’t get anything like that. I think considering it’s a profession where you usually are going at it very much on your own, I think that’s an important thing to have. So that would be the main thing I’d change, the knowledge that there’s still a little bit of support out there in the first twelve months”.* (FYS)
- *“I think much of the further learning comes from time spent in practice treating [a] range of different patients and conditions but to maybe stipulate that they must work alongside other osteopaths for the first year to allow for support in areas of need”* (C/E)
- *“I think there should be some structured form of development programme - it’s fine for those who practice in a clinic like ours where there are more experienced practitioners to bounce off, but any new graduate going into sole practice would I feel struggle to progress their skills quickly enough.”* (C/E)
- *“I have always been able to seek support from my senior osteopaths at the clinics where I work, but would have liked a pre-arranged maybe monthly day or half day session to maintain technical skills etc. and that could have been partly part of registration requirements - as often in the first year you can have periods were you are exposed to very little hands on practice.”* (NR)

Figure 35: Comments on supported foundation period

Nevertheless we received many suggestions about desirable components of a supported foundation period, including those in Figure 36, which emphasised training for mentors, regular reviews, building clinical experience, group learning, online support and factors inhibiting participation. Suggestions in Figure 36 and earlier in relation to mentorship (section 8.4), indicated that study participants had a sense of the transition to practice requiring support for anything between three months and two years. Although one participant stressed that mutual support could be part of a career-long commitment to learning and a cultural matter:

“Exchange of ideas, concerns, discussing interesting and challenging cases is part of the culture in this clinic between us all, no matter how long we have been qualified.”
(C/E)

- *“Training for those who want to take on new graduates.”* (C/E)
- *“Supervisor reporting mandatory for first year, practical help with new patient analyses - better support forums among new registrants from different colleges.”* (C/E)
- *“bimonthly reviews with supervisor/senior colleagues, 'critical friend' to help assess SWOT analysis of new patient records”* (C/E)
- *“chance to treat sufficient patient numbers to hone skills and gain confidence”* (C/E)
- *“I believe the first year after graduating is very important to be busy and get as much hands on work and support and mentoring as possible.”* (C/E)
- *“Group meetings for new graduates, twice in their first year. Supporting them as a group not individually. With experienced osteopaths who could listen to their concerns.”* (C/E)
- *“A post grad problem solving forum a few months post qualification would probably be useful.”* (C/E)
- *May be CPD type groups to come together with other new registrants and highlight areas of weakness and have the opportunity to discuss those with more experienced osteopaths and better their skills* (C/E)
- *A series of regional/local mentor 'clinics' where in particular sole practitioners can come a have an experienced osteopath discuss relevant case notes & cover 1-to-1 technique in a more tailored manner.* NR
- *Principal osteopaths should be required to spend 'CPD' time with associates, especially new registrants.* (C/E)
- *More group workshops within the practice to make them feel supported, valued, contributing to the running of the practice and the profession of osteopathy.* (C/E)
- *Online support. Monthly leading to bi annually tutorials on aspects of technique and business management* (C/E)
- *Improved online learning/support* (C/E)
- *masterclasses by experienced osteopaths* (C/E)
- *reduced price cpd courses for their first year of practice* (C/E)
- *the ones that I meet are interested in CDP but are often burnt out by their training and under financial stress to repay their loans and to earn some money - so may not have time or the mental capacity for too much supervision / mentoring in their first year.* (C/E)

Figure 36: Suggested components of a supported foundation period

8.6 Early engagement with CPD

In effect, either conditional registration or a structured foundation period (section 8.5) amount to early engagement with CPD. We saw in section 7.5.1 that a very high proportion of New Registrants did engage with CPD from the very beginning of their careers. Early engagement with CPD supported New Registrants' transitions into practice in three ways: firstly, plugging perceived gaps in skills or knowledge; secondly, expanding the New Registrants' knowledge and repertoire of techniques; thirdly, and linked to both plugging gaps and extending expertise, early engagement with CPD built New Registrants' confidence in their professional practice. The quotations in Figure 37 illustrate these processes.

- *"I completed a Classical Osteopathic course that ran one weekend a month for a year. This filled a gap in the practical component within osteopathy that I felt I had. I also completed both Level 2 and 3 in Cranial Osteopath, again bridging the practical component that I felt was lacking. On a personal point I found the Academic demands extremely challenging, and I was pushed to the max. This was difficult at the time, however I feel the experience has given me a solid base to work from."* (NR)
- *"Acupuncture Which I think works brilliantly alongside osteopathy"* (NR)
- *"A number of CPD courses to try and achieve greater skill levels and boost confidence."* (NR)

Figure 37: CPD to plug gaps, extend clinical repertoire and build confidence

The majority (65%) of respondents to the New Registrants' Survey identified CPD which they would have liked to access during their first year of practice: by far the greatest unmet need related to business development (which tallies with the findings concerning entrepreneurial and business skills, reported in Chapter 6). Several New Registrants highlighted that appropriate clinical and business courses were available but too costly at a time when they had significant debts (from studying and business start-up costs) and had not yet built up an adequate income.

Some New Registrants wanted greater availability of CPD aimed at New Registrants, focused on common difficulties experienced during the first two years of practice and support to refine their clinical techniques. However, an almost equal number were looking for more advanced technique courses. CPD that addressed the evidence base for interventions was also a frequently identified unmet need, whether in relation to basic or advanced CPD. The following quotations illustrate these areas of unmet need:

- *"Practical sessions where it can actually improve my abilities as an osteopath and to improve patient outcomes"* (NR)
- *"anything targeted at new graduates rather than entire osteopathic profession, diagnostic skills, evidence based treatment approaches; evidence base for currently used treatment approaches."* (NR)
- *"Advanced or furthering manipulative skills, I am finding it difficult to find any courses at this point in time"* (NR)

Interprofessional learning opportunities were also requested by several respondents. As one respondent put it:

“Evidence-based, clinically relevant training that hopefully would include all the different types of professionals that deal with musculoskeletal and pain problems. I get quite fed up of osteopaths not talking to any other professions!” (NR)

Some New Registrants particularly wanted to learn with and from doctors, and a few gave examples of having done this. Extending the theme of interprofessional collaboration, a few respondents desired mechanisms and opportunities to help them better understand NHS services. One respondent described this as follows:

“Opportunities to observe/work within an NHS setting so that we can better understand its complexity/ patient pathways.” (NR)

However, early engagement with CPD was not a priority for all New Registrants, as the quotations in Figure 38 show. However, as we noted in section 7.5.1, there was some concern that the first year CPD waiver, however well-meaning, was a perverse incentive by rewarding non-participation. One respondent wrote:

“We are not required to do CPD in our 1st year and so thereby it didn't encourage you to actively seek it out” (NR)

- *“A course on how to run a successful practice would be useful. Apart from that I believe that I had enough information to absorb and to put into practice from my degree. For me personally, I was in no rush to learn any more without firstly trying to master what I had already been taught.”* (NR)
- *“After 4 years as a student and the pace of the 4th year, I really just needed a break and time to solidify what I already knew and then assess my own weak points and see where I wished to develop.”* (NR)
- *“I think it's good that the GOsC doesn't require us to do any [CPD] in our first year - as their fees already consume spare CPD money”* (NR)
- *“I like the waiver of 10 months for new registrants. It is a manic first year”* (NR)

Figure 38: Comments in support of CPD waiver for first year

Some respondents reported their geographical distance from London and the South East as inhibiting access to CPD. A small number indicated that geographical isolation for other osteopaths limited access to both CPD and mentorship. However, most felt that accessible CPD was available and cost was a bigger inhibitor than geography.

8.7 Working in group practices and multidisciplinary environments

Working in group practices and multidisciplinary environments was thought to confer several advantages for students and New Registrants. We saw in section 4.6 that

opportunities to work in environments external to the OEs provided exposure to conditions that might not ordinarily be seen in OEI clinics and opportunities to work with a wider range of health professionals than might otherwise be possible, including physiotherapists and orthopaedic specialists.

As well as exposure to rarer conditions and consequent knowledge of treatment, multidisciplinary environments enabled students and New Registrants to observe other professionals, discover their modes of communication and language and examine ways in which collaborative approaches could be developed more effectively. It is worth bearing in mind that communication with other professionals was an area that New Registrants found challenging (sections 5.4 and 6.4). Learning how to communicate referrals effectively may be gained by understanding the kinds of information that other professionals value.

Multidisciplinary environments also allowed New Registrants to expand their skills, as the following examples show:

- *“By working in a multi disciplinary setting I have been able to develop skills in manual therapy. These are not specifically osteopathic”. (NR)*
- *“I have been lucky, my transition was smooth. After qualifying I worked as a locum for a chiropractor gaining lots of clinical experience in technique, examination, clinical encounters, practice development, and patient management.” (NR)*

Group practices and multidisciplinary environments, particularly busy ones, were thought to be ideal for building clinical experience quickly, which was thought to be important to protect New Registrants’ knowledge, skills and confidence from ebbing away; although it was thought that it might be necessary to offer incentives for these environments to offer placements and internships. It was assumed that mentorship would be more readily available in group practices, although this is only partly supported by the experiences reported in section 8.4. Typical comments are included in Figure 39.

<ul style="list-style-type: none"> • <i>“I think all new registrants should do 1 year in a busy practice to gain more skills under supervision of senior” (C/E)</i> • <i>“They need to have time in a working busy practice, work experience.” (C/E)</i> • <i>“Ensure group practice and not solo. Maybe offer to subsidise practices that take on new grads.” (C/E)</i> • <i>“Apprenticeship with an experienced osteopath. Graduates that were part of a big and busy practice and were given feedback from their principal were able to develop their skills very quickly. However some osteopaths that had more years in practice they have not developed their skills very well for the reason that for the first 2 years after graduating they had no support and minimal hands on practice due to limited work availability.” (C/E)</i> • <i>“Regular clinical guidance at practice meetings.” (C/E)</i> • <i>“Overcoming the fear of the first patient consultation, which increases with time since qualification.” (NR)</i> • <i>“I feel that there were not enough opportunities for me to practise after leaving college. It took me 5 months to see my first patient (other than friends and family).” (NR)</i>

Table continues overleaf ...

- *“Students are well trained as clinicians but not as business professionals, so that most graduates I know spent the first 18 months struggling to find work, which leads to deskilling & disillusionment. I think graduates would benefit from having internships or placements immediately post qualification so as to ensure skills and knowledge is immediately put into place and not lost.” (NR)*
- *“All newly qualified practitioners should have to work in clinics much like chiropractors so they are able to gain the knowledge and skills necessary to be safe confident practitioners. Unfortunately this is not the case with many newly qualified osteopaths not experiencing enough clinical encounters per week a) to earn a living, b) to gain any worthwhile experience.” (NR)*
- *“I was glad I had approachable former lecturers that I could e-mail initially as I was working on my own, away from any osteopath I would know of. However I tried to not do it too much (as we are a lot of former students). Now I work with two more experienced osteopaths, and I feel that it is what should happen when we first start as an osteopath. Everyone is a bit restricted with time, but I still have the peace of mind that I can ask or turn to another more experienced osteopath if I need to” (NR)*
- *“There is no career structure. A physio once told me that he felt he made no difference to any of his patients in his first year. 15 years later patients travel from abroad to see him. He had a structure that enabled him to treat patients on a regular basis and to build his skill and knowledge. For osteopaths, associate positions are generally (understandably) only available to osteopaths with several years experience. This means that we have to have a certain amount of capital to rent premises and take a loss whilst building a practise. It would be great if there were assistant roles or even voluntary roles to enable new graduates to gain experience.” (NR)*
- *“It appears to have been a really quiet year and at times you question whether that’s is the market or your newly and less experienced skills. Looking at the appointments of fellow more experienced osteopaths I now know it has been the market, but that took some time.” (NR)*

Figure 39: Comments on working in group practices and multidisciplinary environments

8.8 Ongoing support from OEI or faculty

As we noted in section 8.4, some faculty were willing to support their former students during the transition to osteopathic practice. We cannot be certain, but the data appears to indicate that, mainly, faculty did this on an individual voluntary basis rather than as part of an OEI-supported commitment to ongoing support for graduates. At least one OEI seemed to offer ongoing support to graduates, provided by tutors and an intranet discussion forum, but this was unusual. One New Registrant described the discussion forum as follows:

“The [OEI] has an online informal discussion board for graduates, which is monitored by a senior tutor. This is very useful for new registrants to obtain support.” (NR)

Faculty from some OEIs indicated that the extension of OEI support to alumni was under discussion. For example, we noted in section 7.4.2 that New Registrants were concerned about a lack of affordable access to journalsⁱⁱⁱ and other resources from which they might develop their knowledge to underpin practice; faculty from one OEI said that this need was recognised and the possibility of alumni library access was under investigation.

ⁱⁱⁱ In fact all UK-registered osteopaths have unrestricted access the contents of a range of research journals via the GOsC **o zone** web site (see footnote on page 111 for an indicative list of titles).

Telephone and email mentorship from faculty was noted in section 8.4.1. In a further example, a small number of New Registrants reported that as a group, in collaboration with a former tutor, they arranged a CPD session, which was described by one participant as:

“Afternoon with group of fellow recent grads and old tutor covering a range of subjects we'd all requested.” (NR)

Other New Registrants reported attending *“technique sessions”* at their former OEI.

New Registrants from different OEIs experienced different levels of ongoing support. Furthermore, the individual and voluntary nature of most tutors' support activities made it very likely that even among the graduates of one OEI, there would be variation in the availability of faculty support.

Not everyone thought that ongoing OEI support should be voluntary and a matter of market positioning. One respondent to the Colleagues' and Employers' survey wrote:

“Osteopathic colleges to provide post graduate support networks and events to new graduates and refresher training for graduates. I would like to see this a compulsory requirement for college recognition.” (C/E)

8.9 Summary

There are many ways to support New Registrants' transitions into practice, good quality clinical education within osteopathy degrees forming the foundation. After that the most widely practised and least contentious form of support was mentorship, which was valued by all stakeholder groups, although experiences of mentorship were very variable. Sustainability and quality were the primary concerns of study participants in relation to any extension of mentorship. Some worried about oppressive oversight, loss of autonomy and increased potential for exploitation if the profession moved towards more formal mentorship. There was limited support for a period of conditional registration or a structured foundation period. Many practising osteopaths preferred to support transitions to practice by strengthening clinical education during osteopathy degrees.

A high proportion of New Registrants engaged with CPD from the very beginning of their careers to fill knowledge gaps, extend their expertise and consequently their service to patients, and to build confidence. Study participants highlighted the value of working in group practices and multidisciplinary environments to achieve the same outcomes.

We noted that OEIs and faculty continued to support their former students after graduation and this provision seemed likely to expand, although there were concerns about sustainability and inequality.

Chapter 9 Findings: Emergent and cross-cutting themes

9.1 Précis

Three major cross-cutting themes emerged in the preceding chapters: 'Safe, if not always effective', 'Diversity, Variability and Uncertainty' and 'Autonomy and Isolation'.

While it is essential for novice practitioners to be safe practitioners, it was thought that the heavy emphasis on safety during osteopathic education produced over-cautious and insufficiently discriminating practice. The heavy emphasis on safety may also be to the detriment of other aspects of osteopathic practice, such as developing osteopathic reasoning, interpersonal skills and business acumen. These things may limit New Registrants' effectiveness and leave them under pressure to learn a great deal during the initial months of practice, during which they may be relatively unsupported due to the high incidence of self-employment and patchy mentorship. Yet it was awareness of the high incidence of self-employment and patchy mentorship that drove the great emphasis on safety during initial education.

There was marked diversity, variability and uncertainty at all stages of osteopaths' development from students to competent practitioners. Student cohorts can be very mixed, with a large proportion of mature students with diverse past careers and life experiences. Faculty sometimes struggled to match the curriculum to everyone's needs. Clinic and placement education varied between OEIs and, even within each OEI, clinical assessments were regarded as somewhat variable. Following graduation, experiences of employment conditions, mentorship and other support for development during the early months of practice were extremely variable. It was impossible to identify a 'typical' trajectory for a new Registrant, perhaps apart from reality shock in relation to the long and arduous process of building a patient base.

Autonomy was very important to the study participants and had several interwoven, sometimes slightly contradictory strands. Autonomy was prized in its own right, but also for commercial necessity. Independent, possibly isolated, practice was the only option for many, which placed a premium within osteopathy degrees on learning for safe, self-directed practice. The high value placed on autonomy could make it difficult for practitioners to ask for help or advice. Many New Registrants, including those working within group practices expressed a sense of isolation during their early months of practice.

9.2 Introduction

Throughout the findings relating to clinical knowledge and skills (Chapter 4), interpersonal and communication skills (Chapter 5), entrepreneurial and business skills (Chapter 6), professionalism (Chapter 7) and supporting osteopathy graduates transitions into practice (Chapter 8), three major cross-cutting themes emerged, which will be summarised in this chapter. They were: 'Safe, if not always effective' (section 9.3), 'Diversity, Variability and Uncertainty' (section 9.4) and 'Autonomy and Isolation' (section 9.5).

9.3 'Safe, if not always effective'

In Chapter 4, which focused on clinical knowledge, skills and competences, a strong discourse of 'safe, if not always effective' emerged. This related to New Registrants' command of knowledge, competence in a limited range of clinical techniques, thoroughness and a cautious approach to practice. Many study participants thought this was a reasonable level of expertise with which to commence professional practice, as we saw in Chapter 4 and further illustrated by this quotation:

"The schools should make it clear that after 4 years training a new graduate can be expected to be no more than safe, but with the skills to be able to develop their osteopathic practice. The greatest learning comes after graduation when those taught techniques & procedure should develop into innate osteopathic understanding and skill." (C/E)

While the thrust of being clinically competent is, naturally, to ensure patient safety first and foremost; the issue of effective osteopathic intervention follows closely behind, not least to meet patients' expectations. However, faculty and students repeatedly described the emphasis within clinical assessments (and consequently clinical education) as resting with safety, with greater ambivalence about effectiveness. The following quotation is a typical example:

"I think the clinical competency assessment the emphasis is pretty much primarily on safety rather than actually on clinical effectiveness ... I think that you could argue that a lot of the students, and I think you'd probably pick that up by talking to principals and the guys are extremely safe they may not be clinically effective..." (Faculty)

This commonly occurring perspective makes it necessary to examine more closely what is meant by safety and effectiveness. Within OEs (faculty and students) safety was almost exclusively framed as avoiding treatment mistakes. The focus group extract in Figure 4 (section 4.3.2) is an example of this framing (see also participant 2 in the focus group extract in Figure 3). OEI faculty and students did not talk about psychological safety for patients, workplace safety for osteopaths and patients, or reputational safety for themselves and the profession.

New Registrants viewed effectiveness as making better-focused clinical decisions, good clinical outcomes and successful holistic patient management. Ongoing development of interpersonal and communication skills was thought to be central to these things (sections 5.4 and 6.4) and both expanding and refining expertise through early engagement with CPD (section 7.5.1). They cited returning patients and word of mouth recommendations as evidence of effectiveness (sections 5.4 and 6.4). A small number of New Registrants made unprompted references to evidence based or evidence informed practice, as we saw in sections 7.4.2 and 8.6. One respondent elaborated as follows:

“I think there is a need for cpd programmes that have some evidence base or have a shown clinical efficacy and safety or at least have a 'reasonable' conceptual basis.”

(NR)

Effectiveness as defined by selecting evidence based or evidence informed interventions was not mentioned by other stakeholder groups.

Colleagues and Employers agreed that New Registrants were highly likely to practise safely and many thought they would ask for help if required (sections 4.5.2 and 8.4.2). But these experienced osteopaths felt New Registrants' effectiveness was limited by being over-cautious; insufficiently selective with tests and treatments; insufficiently critical and integrative in their clinical reasoning and insufficiently patient focused, leading to both over- and under-treatment (sections 4.3.1, 4.5.2 and 5.3). They suggested New Registrants needed to develop a better appreciation of: the recovery process; the impact of interpersonal skills; when to seek advice; intra- and interprofessional communication; and complexity in patients' conditions and circumstances (sections 4.5.2, 5.3 and 6.3).

Colleagues and Employers also suggested that unrealistic expectations of patients or the recovery process limited New Registrants' clinical and business effectiveness (section 6.3). Colleagues' and Employers' comments on over-caution, linked to ineffectiveness included the following:

- *“The schools tend to teach them to be safe which should just be the first stage of practice. ie 1st year safety is paramount. They just have no idea how to evaluate properly. Mechanisms should concentrate on evaluation protocols and constant re-evaluation when treating.”* (C/E)
- [They need] *“Encouragement to take on responsibility for total patient care at undergraduate level, together with a far less defensive manner in the clinical setting. There is such an emphasis on safety and on following GOsC protocols as to stifle the primary objective of patient care”* (C/E)

In Figure 40, four New Registrants give their views on the consequences of the degree of emphasis on safety within osteopathy degrees. The fourth quotation is perhaps the most worrying, since the clinical rationale for tutors' advice seems not to have been learnt and the doubt expressed does not appear to connect to seeking out relevant postgraduate training.

- *“it is NOTHING like doing clinic work during the degree being fearful of GoSC even though I know deep down I have no need to be - it's being almost OCD about making sure everything is done to the letter - it doesn't really allow you to relax much or enjoy your work” (NR)*
- *“I think I came out of college as a very competent and safe practitioner, but perhaps not an osteopath thinking osteopathically. This is something that has come with more CPD and more experience. I spent the first year of practice petrified of patients complaining to the GoSC about me. This was something that was drummed into us during our clinical training, to expect to be hauled up at least once in our career.” (NR)*
- *“as we were being assessed throughout much of our student clinic experience (with emphasis on safety) there didn't seem enough opportunity to learn and apply effective techniques in the clinical environment using tutor experience. Perhaps this could be addressed by going through final practical exams earlier in the spring with opportunity afterwards to focus on the treatment plans in more relaxed environment” (NR)*
- *“I found that in my [final] year there was a lack of cohesion in the approach applied by tutors in regards to what they did or did not let you do. Mainly I believe that this was due to the insurance issues. I also believe that in many instances that tutors concerns for safety particularly when cervical manipulation was involved were a hindrance. In many instances I was prevented from carrying out manipulations when I believed that was the best treatment modality for the patient. This left me with an area of doubt when I initially moved into practice on when to manipulate.” (NR)*

Figure 40: New Registrants views on the consequences of the dominant safety focus within osteopathy degrees

All stakeholder groups appeared to believe that increased effectiveness would naturally develop through gaining experience of osteopathic practice. A small number from the Colleagues' and Employers' group adopted an overtly Darwinian stance, arguing that effective osteopaths would build successful businesses, while the ineffective would experience businesses failure and leave the profession. There was no mention of the possible impact of ineffective osteopaths on the reputation of the profession as a whole.

9.4 Diversity, Variability and Uncertainty

Perceptions of diversity, variability and uncertainty pervaded accounts of New Registrants' preparedness to practise. We noted Employers' and Colleagues' perceptions of diversity, usually expressed as variability, in New Registrants' initial skills and attitudes in clinical, interpersonal and business aspects of practice (Chapters 4-6). In fact one survey respondent went so far as to write:

“They are all different - it is pointless to generalise”

Certainly, New Registrants' self-evaluations of their strengths and weakness were surprisingly diverse over the domains of clinical knowledge, clinical skills, interpersonal and communication skills and business acumen (sections 4.5.1, 5.4 and 6.4). At one level, everyone is different and diversity is enriching; but many elements of the discourse of Diversity, Variability and Uncertainty stressed the uncertainty, inequality and additional demands associated with several aspects of the diversity and variability which was

encountered. For example, the diversity of New Registrants strengths and weaknesses created uncertainty for Colleagues and Employers each time a New Registrant joined a group practice. Variations in New Registrants' clinical expertise interpersonal skills and self-awareness, in particular, had unpredictable effects on group dynamics and perceived benefits or threats to the group practice. The type and extent of support the newcomer would need was uncertain. Related to this, and irrespective of need, levels and styles of support from Colleagues and Employers were rather variable (Chapters 4 and 8): creating uncertainty for Final Year Students and New Registrants seeking associate or temporary positions in group practices.

Diversity among New Registrants' knowledge, skills and approaches to practice, was thought to be increased by distinctive emphases within different degree programmes (section 7.3.3), although all graduates would have demonstrated competence in relation to a common core of knowledge and skills. This common core was not articulated by study participants and this study did not include an analysis of curriculum documents, which might have identified some formal elements of the common core (although such documents are indicative summaries of intent rather than records of learning). It was thought that some practice principals tried to minimise their uncertainty by recruiting New Registrants from OEI programmes with which they or a trusted colleague were familiar (section 7.3.3).

However, variability within degree programmes was just as much a concern as variability between programmes. Lack of consistency in clinic learning, feedback and assessment was highlighted by both faculty and students (section 4.6). There was noticeable variation in the clinic opportunities that each OEI could offer and the extent to which students participated in all aspects of running the in-house clinic. Students had some concerns over the range of techniques taught and recommended by different tutors to address similar symptoms. Partly this was confusing when students were faced with deciding what to do; partly it inhibited practise and consolidation of a more limited range of skills. As one New Registrant put it:

"Too many different variations taught that I felt 'I fell between a number of stools' and was master of none, whereas I would have liked to have been master of one, at least to take into practice." (NR)

Students were also concerned about variation in the amount of support offered to individual students, variability in formative feedback from clinic tutors and about the diversity of approaches adopted by clinical examiners. Both faculty and students had doubts about whether individual students could be assessed equally when the complexity of patients requiring treatment is likely to be variable on any day of assessment (section 4.6).

Similarly, patient- and tutor-based variation affected the development of students' interpersonal and communication skills (Chapter 5), which was heavily dependent on the level and variety of challenges students met in clinic, and on rather variable role modelling from clinic tutors. The reality for students was of mixed experiences – from the very good to the awful.

In addition to variability in curriculum attention to developing interpersonal skills, the extent and quality of business-related education varied between OEI's (sections 6.4 and 6.5). But overall there was little attention to the role of clinic and placement experiences in developing expertise and realistic expectations for these areas of professional practice. Interestingly, osteopathy students and New Registrants are heterogeneous in respect of their earlier careers and life experiences. While some undertake osteopathy degrees straight from school, many are mature students turning to osteopathy after other careers or family commitments. Faculty noted the influence of earlier careers on students' variable interest in the business-related and communication skills elements of the curriculum, but did not talk about harnessing the expertise of some students to support the learning of the whole group (sections 5.5 and 6.3).

Experiences of mentorship were extremely varied (section 8.4): ranging from close supervision, which some might find oppressive; to mentorship with a mixture of proactive and reactive elements; to a range (from generous to fleeting and grudging) of reactive mentorship in response to requests for help; to total absence. Mentorship was predominantly provided by practice principals and faculty from the New Registrant's former OEI, but New Registrants also sought and received mentorship from a variety of other sources such as CPD groups, peers and family. Many mentorship arrangements were informal and some New Registrants were very uncertain about what they could reasonably expect.

Some experienced osteopaths enjoyed working alongside and mentoring New Registrants. They felt that the learning and development that ensued from mentorship could be a two-way process, not just a unidirectional flow of wisdom from experienced practitioner to novice (section 4.3.1): we identified these as 'expansive' learning environments.^{25,26} Other mentors thought in terms of a one-way flow of expertise from themselves to the novice, which at times, was experienced as a burden. A small group of experienced osteopaths associated a need for mentorship with inadequate preparation during osteopathy degrees.

There were some reports of unequal access to CPD and mentorship, based on geographical isolation. However, there were more responses that focused on the variable quality of CPD and the uncertainty this created when selecting CPD courses.

There was no consensus on osteopathic values, the nature of osteopathic practice and the nature of evidence for practice (sections 7.3 and 7.4). This related to autonomy, which will be discussed in the next section. One New Registrant also commented:

"The broad spectrum of practitioners and how osteopaths diversify once graduated is extolled as a benefit of the profession; it would seem to be a gift and a curse." (NR)

9.5 Autonomy and Isolation

There were five main aspects to the emergent cross-cutting theme of Autonomy and Isolation: preparation for autonomous and possibly isolated practice, the symbolic role of the case history and developing self-direction and self-assessment as part of an incremental journey towards autonomous practice, tensions and mixed messages in the discourse of autonomy and, finally, the experience of isolation.

All healthcare professionals need to be prepared to act autonomously and accountably, but the high incidence of self-employment and the number of osteopaths who practise alone drive a particular emphasis within osteopathy degrees to prepare New Registrants for autonomous practice (sections 3.3.4, 3.4.3 and 4.3.3). The main components of this were identified as clinical knowledge, clinical skills, emphasising safety and adherence to standards for practice (sections 4.3.3, 4.6.2, 7.3 and 9.3). Sometimes osteopathy degrees' emphases on these aspects of practice were felt to be to the detriment of learning related to other aspects of practice, such as osteopathic values and principles (section 4.3.3), interpersonal skills (Chapter 5) and preparation for building and sustaining a business (Chapter 6). Paradoxically, too great an emphasis on safety was thought to limit the effectiveness of clinical practice (section 9.3). Even within group practices there was an emphasis on New Registrants being prepared for autonomous practice due to highly variable and often quite limited support from Colleagues and Employers (section 8.4). Although there was much emphasis on developing autonomous practitioners, this did not come without its concerns. Faculty at all OEI's encouraged autonomy but there was also a reticence as to its purpose, for whilst there was confidence that graduates leave as safe practitioners, they are at an early stage in their development where levels of autonomy may outweigh clinical capability.

Symbolically, the concept of the Case History is significant. The ability to firstly take an accurate and informative case history which then provides the platform for an effective treatment plan is seen as a benchmark for autonomous clinical practice. Theoretical and clinical learning is therefore geared up towards ultimately making informed judgements and decisions. Emphases on self-directed learning and self-assessment were also symbolic for faculty and students. A number of programmes operated at masters degree level, and this influenced the expectations of learning autonomously and critical thinking. Aside from the requirement to have an acceptable level of theoretical knowledge and clinical osteopathic skill, independent learning and critical thinking were considered two of the most fundamental attributes that would support the ability to function autonomously: the idea of self management for effective patient management. Students needed to build their capacity to make decisions and practise autonomously in an incremental fashion during their degree programme. However, students reported some variation in their capacity to practise autonomously towards the end of their programmes, with some clinic tutors having more presence than others in clinic settings. Part of this could be due to institutional insurance requirements, but learners themselves primarily suggested that some clinic tutors were, in

their view, overly cautious. In addition, we noted in Chapter 4 that there may be a need to pay more attention to the consolidation of clinical techniques during the final months of osteopathy degrees.

“What it’s about is ‘Are these people competent in what they do?’, can they make a decision and have they been enabled, which is coming back to [name]’s point, because actually once we get out there they are completely under their own cognisance, they are going to do whatever they want to do anyway so actually it’s all we can do to make them relatively open minded about things. After that you have no control over them at all”. (Faculty)

There were also tensions and mixed messages surrounding autonomy. One strand of this was autonomous practice as a commercial necessity, not necessarily a career preference. Another strand was a strong desire for mentorship and structured employment opportunities. Another was frustration with the restriction of autonomy through (what was perceived as rather prescriptive) regulation by the GOsC and a plethora of regulations that apply to all small businesses. A further strand encompassed valuing diverse interpretations of osteopathic practice, but recognising that the lack of a clear single voice may disadvantage osteopathy in comparison with competing professions that appear to be more cohesive. One collective marker of autonomous osteopathic practice was adherence to codes of practice, though interestingly not exclusively, as another marker of osteopathy was its flexibility and variation of standards in application. The narratives emphasised that the intervention conducted is often one which is based on ‘it depends’ as opposed to an algorithm found in a textbook. There were also differing perceptions of what being professional entails: some suggesting that being a professional lies entirely with the new registrant and their conduct, others that it is the role of the profession to support the new registrants under its auspices, offering a mixture of direction, guidance, and technical advice to enable development. The diversity and complexity of conceptions of autonomy link back to the previous cross-cutting theme of Diversity, Variability and Uncertainty and undoubtedly reduce the likelihood of the community of osteopaths responding to policy formulation in a cohesive manner.

Unfortunately, the ultimate extension of autonomy is isolation and a discourse of isolation also permeated the data. Faculty were very aware that some New Registrants would be practising alone, which drove them to prioritise safety in clinical education and to volunteer ongoing support to graduates. As we saw in section 6.4, many New Registrants felt isolated, unsupported and lonely in the early months following graduation, even some who worked in group practices. This took its toll on New Registrants’ clinical confidence. Figure 41 contains typical comments from New Registrants who identified isolation as one of their biggest challenges in the transition from student to practising osteopath. A structured foundation period or more extensive mentorship were seen as powerful means to reduce isolation (sections 8.4 and 8.5), although there were concerns about sustainability and loss of autonomy.

Isolation also applied to inhibitions about sharing problematic practice issues with other practitioners. Anecdotally, there were some comments shared in conversation with faculty staff outside of the focus groups who suggested that in some cases osteopaths may feel vulnerable and unwilling to share aspects of practice with colleagues as this may create perceptions of limited ability or knowledge. Osteopathy is a small field, where information could conceivably pass quickly across it, and this may affect practitioner's willingness to consult with others.

At various points across the data set we saw strong identification with the OEI at which practitioners studied, which sometimes left practitioners from other OEIs feeling marginalised and isolated (e.g. section 8.4.1.1). The inevitable business competition between neighbouring osteopaths also supported a sense of isolation.

- *"the initial solitude."* (NR)
- *"being without supervision or peer support, and the discussion and learning that brings"* (NR)
- *"The lack of support/morale going from working alongside many to being by yourself."* (NR)
- *"Both challenging and rewarding when it is going well - the fact that I am alone and solely accountable for what happens."* (NR)
- *"In some ways it was both liberating and a little unsettling to no longer have a tutor to check your findings"* (NR)
- *"Going from being backed up continuously to being out on your own with a patient expecting you to make them better."* (NR)
- *"going it alone and not having anyone to ask or lean on. To have confidence in what you do without the safety net of being a student"* (NR)
- *"having no safety net or someone to consult for a second opinion. We should be weaned off supervision gradually, not suddenly."* (NR)
- *"Having started my own practice, all decisions regarding diagnosis, treatment plan and referrals have become purely my responsibility"* (NR)
- *"starting out on your own with no mentors to go to for reassurance."* (NR)
- *"The knowledge of full personal responsibility for a patient and legal implications of this."* (NR)
- *"I don't feel like I have much support from anywhere or anyone - a magazine or email now and again that I don't always have the time to read aren't really any kind of meaningful support - I feel a little like I'm in a vacuum."* (NR)
- *"When you first start practising it can be very lonely, as the nature of the job means that you will probably not working alongside another osteopath on a daily basis. Having gone from being cosseted as such at college and surrounded by your fellow students all going through the same processes you are all alone and any decisions you make are all your own!"* (NR)

Figure 41: New Registrants commenting on isolation

9.6 Summary

Exploration of the discourse of 'safe, if not necessarily effective' showed that it set thresholds for clinical education and assessments that focused on safety, possibly to the detriment of other aspects of osteopathic practice such as well-developed interpersonal skills and business acumen. Beyond the obligation of all professions to safeguard the public, the main drivers for great emphasis on safety were the high incidence of self-employment and patchy mentorship for New Registrants. However, the result was considered to be an over-cautious and insufficiently discriminating style of practice among New Registrants, which limited their effectiveness and left much to be learnt during the initial months of practice. It was suggested that greater attention to consolidation of a range of clinical competences during the final months of degrees would be beneficial.

Diversity and variability were identified throughout the journey from student to competent practitioner. Clinic education during degrees and the mentorship of New Registrants were perhaps the most significant sites of variability, leaving some feeling well-prepared and well-supported while others had much more difficult experiences. However, diversity was prized as a facet of autonomy.

Autonomy was both central to the self-image of osteopaths and simply a commercial necessity. Osteopathy degrees had to prepare graduates for autonomous practice and the potential for isolated practice so they placed great store on safety, self-evaluation and self-reliance. Some New Registrants then bridled at restrictions to their autonomy from regulations and practice principals. However, most New Registrants desired more structure and support during their early months in practice. This did not always sit well alongside colleagues' expectations that they should be proactive and fairly self-reliant, but seek help when required as a manifestation of autonomous self-evaluative practice. Many New Registrants experienced significant isolation during their early months of practice, including those working in group practices.

Part III: Discussion and recommendations

Chapter 10 Discussion

10.1 Introduction

This chapter will discuss the findings presented in Chapters 4-9 in relation to the central question of what is the nature of New Registrants' preparedness to practise; setting the empirical findings from this study in the context of other professions' experiences and the wider literature concerning facets of preparedness to practise and workplace learning.

Preparedness to practise is a complex multifaceted phenomenon. It was generally agreed that clinical knowledge and competence in a range of clinical processes formed the bedrock of preparedness to practise safely (Chapter 4 and section 10.2.3). However, well-developed interpersonal and communication skills are also essential to explain the potential and limits of osteopathy, ensure ongoing informed consent in all clinical interactions, obtain a good quality case history to guide diagnoses and treatment proposals, provide realistic patient-centred advice, collaborate with other healthcare professionals and build a successful business. Thus, interpersonal and communication skills are part of clinical competence and an important aspect of preparedness to practise (Chapter 5 and section 10.2.4).

The majority of osteopaths are self-employed and must build a successful business. Consequently, preparedness for entrepreneurial work and running a business competently was a strong theme in this study (Chapter 6 and section 10.2.6). A high proportion of osteopaths work alone: in their own single-handed practice, in a group practice where different practitioners work on different days and do not overlap, or in multidisciplinary health and wellbeing environments where they are the only osteopath. Consequently preparation for practice often has a focus on preparedness for isolated, autonomous practice (Chapter 9 and sections 10.2.1, 10.2.2 and 10.2.8).

Binding together all these aspects of professional practice, professionalism must infuse osteopaths' actions and attitudes in self-monitoring of expertise and performance and in their clinical and business dealings with members of the public, their colleagues and other healthcare professionals (Chapter 7 and section 10.2.6). Although, for clarity, these things will be discussed separately in this chapter, they are greatly intertwined and it is often difficult to consider one facet of professional practice without including another.

Mirroring the structure of Chapter 8, section 10.3 discusses mechanisms identified during this study which have potential to support New Registrants' transitions into practice. In section 10.4 we will discuss the positioning of osteopathy in relation to other professions. Sections 10.5 and 10.6 discuss the trustworthiness of the findings and interpretations presented in this report, and the limitations of the study.

10.2 Perceptions of New Registrants' preparedness to practise

10.2.1 'Safe, if not always effective'

The consensus was that New Registrants were safe to practise. The discourse of 'safe, if not always effective', which was identified as an emergent cross-cutting theme in this study, underlined that whilst safety is an essential component of preparedness to practise, it is not enough. This study found a perception among faculty that osteopathy degrees placed such emphasis on safe clinical practice that it displaced attention from other aspects of professional practice. This perception was echoed by New Registrants and final year students. The experienced osteopaths who responded to the Colleagues' and Employers' survey went so far as to suggest that it was possible to have too much of a good thing, in the sense that they regarded New Registrants' practice as overly cautious, which led to both under- and over-treatment.

The discourse of 'safe, if not always effective' recurred in the focus group narratives and was expressed by both students and faculty. Having internalised this judgement of their competence upon graduation, students would be expected to carry this self-image into their early months as New Registrants. They would be able to focus on continuing to be safe and derive confidence from that at a time when their confidence was fragile. However, almost immediately New Registrants felt the pressure of patients' expectations and their own ambitions to provide effective care and a good customer experience. Their practice was hesitant, restricted in the range of skills and techniques they could successfully deploy; not always as effective as they or their patients wanted. It was easy for confidence to ebb away. One New Registrant summarised the greatest challenge of the transition from student to New Registrant as:

"Keeping confident in one's own abilities, when it is so obvious how much there is still to learn, and knowing that one could have done better with some patients." (NR)

But how was it expected that New Registrants would make the transition from 'safe, if not always effective' to 'safe *and* effective'? All stakeholder groups in this study thought this would arise from gaining experience in clinical practice. Some study participants also mentioned mentorship and engagement with CPD as mechanisms to enhance or complement gaining practical experience. The wider literature on learning from practice and workplace learning may offer some useful insights to support study participants' intuitive belief in the need to gain practice experience and the benefits of mentorship and CPD, but also to highlight that some types of experience are more valuable than others.

Firstly, to learn from practice sufficiently well to become expert, *deliberate practice* is required: this is *effortful* practice, supported by *feedback* (from others or from the environment), with the *deliberate intention to improve*.^{34,35} This supports the (sometimes relatively recent) emphasis within osteopathy degrees on developing reflective practice, but means that the lack of mentorship or other opportunities for feedback from more experienced practitioners is a matter for concern. At present, many newly registered

osteopaths primarily derive feedback from patients' clinical progress, whether patients return and receipt of word of mouth recommendations.

Secondly, conversations with an experienced 'guide' who possesses and overview of a domain of knowledge or practice, enables people to transcend what they could learn without such a guide. This is known as 'scaffolding'^{36,37} or 'mediation'³⁸ and is one of the processes at work in effective mentoring.^{iv}

Thirdly, workplaces differ in respect of opportunities to learn, termed 'affordances'.³⁹ Affordances shape the potential richness of practitioners' learning. For example, osteopathic practices with a wide range of patients offer richer affordances than more homogeneous settings; as would moderately busy clinics, because novice and experienced practitioners would see a large number of patients but still have some time for reflection, mentorship and CPD. Similarly, workplaces where colleagues interact in a spirit of collaborative development will afford rich learning opportunities for all participants, regardless of length of experience. But even within the same workplace, affordances can be distributed unequally due to part-time working, perceptions of an individual's competence, personal relations and cliques.³⁹ Paradoxically, those newcomers who are perceived as most competent usually get most support to develop further.⁴⁰ In this report we noted that osteopathy graduates' employment prospects, the availability of post-graduation OEI support and the availability of mentorship were thought, to some degree, to be affected by the OEI from which they graduated (sections 7.3.3, 8.8 and 8.4.1.1). More generally, affordances arising through mentorship and less formal support were highly variable (section 8.4). However, workplace and mentorship affordances would not be the only areas for development because people vary in their past experiences and personal agency (individual construction of experiences, engagement and learning) and consequently people differ in their abilities and predispositions to respond to workplace and wider professional affordances.^{39,41,42} Osteopathic degrees have a role in supporting the development of appropriate personal and professional agency.

The discourse of 'safe, if not always effective' appeared to have two distinct functions. On the one hand it seemed to be an attempt (by faculty and subsequently by experienced osteopaths) to underline to new graduates that they still had much to learn. On the other hand, the discourse appeared to be a statement by OEIs about the threshold they were using for graduation, which then guided clinical assessments and determined curriculum emphases (sections 4.3.3 and 9.3). It also shaped what were considered to be realistic expectations of new graduates' competences. Only a tiny proportion (<2%) of the responses to the New Registrants' survey gave the impression of over-confidence and reports from Colleagues and Employers about New Registrants' over-confidence were also sparse. Most New Registrants were acutely aware of how much they needed to learn and

^{iv} The concepts of scaffolding and mediation have their heritage in studies of children's learning and development, but many have found them useful in relation to adult and professional learning.

were enthusiastic to engage in mentorship and CPD (see for example, sections 7.5, 8.4.1 and 8.6); some were significantly hampered by inappropriately high anxiety and low confidence (for example see section 4.3.1, Figure 17 and Figure 40).

We will see in the next section that safety is the dominant threshold for completion of health professions' programmes, so osteopathy is not unusual. However, the CBI has questioned whether UK degrees in general, are sufficiently ambitious in the level to which they seek to develop students' workplace skills.¹² Since osteopathy graduates are relatively unusual among health professions graduates with regard to high levels of self-employment and isolated practice, the question of whether 'safe, if not necessarily effective' is sufficiently ambitious becomes pertinent. Perhaps osteopathy degrees need to place a little more emphasis on effectiveness. This could help New Registrants to build a satisfied patient base more quickly and, logically, would safeguard or even improve the profession's reputation and levels of interest in osteopathic treatment. In this study, experienced osteopaths suggested that osteopathy graduates were insufficiently critical and discriminating in their clinical reasoning, leading to insufficiently focused interventions. This may be a fruitful area for development in osteopathy degrees.

However, it is inevitable and essential that safe practice is the 'bottom line' for osteopathy degrees. This is particularly so because of the high incidence of isolated practice. Other health professions generally have novice practitioners located in (often multidisciplinary) teams, where the risks posed by novice practitioners are significantly mitigated through the awareness of other practitioners involved in team-based care and because the novice practitioner can usually call for assistance from a more experienced practitioner, which will normally be provided fairly quickly. Novice practitioners in all professions remain accountable for their clinical practice, but those working in team-based care or supervised training positions often have better back-up than many newly qualified osteopaths.

In addition, most of the health professions that are embedded within the NHS have experienced an increase in protocol-based care. (Protocols appear in various guises and are variously named, for example checklist, clinical guideline, clinical standard and care pathway.) Although many practitioners have expressed concerns about loss of autonomy and patient-focus, some protocols do seem to be easing novice practitioners' transitions into practice⁴⁰ and, used intelligently, they do not replace clinical judgement and can increase interprofessional collaboration and patient-focus. Although osteopathy students appear to learn some algorithms, particularly in relation to obtaining consent and 'red flags' for referral on to medical supervision, it is accepted that the holistic practice of osteopathy offers limited scope for the use of protocols. However it may be possible to introduce students more extensively to what might be termed 'treatment scripts' (to borrow from the medical idea of 'illness scripts' that support clinical reasoning and decisions, particularly diagnosis).⁴³ We suggest that such treatment scripts would include, not only osteopathic reasoning, diagnosis and the associated selection of investigations and treatment options,

but also elements focused on areas in which this study's participants suggested New Registrants were weak, such as tailoring treatment to patients' circumstances, realistic expectations of the recovery period and promoting self-care. Weaving awareness of such treatment scripts into learning for and during clinic experiences, could help shorten the journey from 'safe, if not always effective' to 'safe and effective'

Within OEIs (faculty and students) safety was almost exclusively framed as avoiding treatment mistakes. A very small number of Colleagues and Employers highlighted reputational risks to osteopathic practices arising from the presence of a New Registrant. Across stakeholder groups, study participants did not talk about psychological safety for patients or osteopaths, workplace safety for osteopaths or, with few exceptions, reputational safety for themselves and the profession. It seems that conceptions of safety could be widened.

10.2.2 Being sufficiently well prepared to commence practice

It was clear that many Colleagues and Employers regarded New Registrants as possessing important knowledge, skills and enthusiasms; sufficient to begin practice, but in need of additional support, a period of consolidation and refining practice, and opportunities to broaden their experience during the long process of building a patient base (sections 4.3.1 and 4.5.2). Just over half the respondents in the Colleagues and Employers group thought New Registrants were sufficiently prepared for clinical practice and 10% thought they were very well prepared (section 4.3.1). There was considerable overlap in the perceived strengths and weaknesses of New Registrants' preparedness between Colleagues and Employers who were positive and those who doubted that preparedness was sufficient (section 4.5.2), suggesting differences in calibration. Lack of integration and excessive caution, linked to over-investigation or over-treatment, were common concerns, but Colleagues and Employers varied in the extent to which they viewed these as indicative of lack of preparedness to practise or an expected and transient part of beginning practice (section 4.5.2).

Faculty stressed that degree-level preparation was directed toward preparation for safe autonomous practice, which must be underpinned by substantial knowledge and adherence to standards for practice (sections 4.3.3, 7.3 and 9.3). The main argument made for such depth of clinical knowledge was to underpin *independent* practice. Focus group discussions with final year students revealed that, as they approached graduation, they felt ready to work with patients, but thought they still had a great deal to learn (section 4.3.2). They considered that they possessed a substantial knowledge base and had become competent in key diagnostic and treatment processes, but anticipated extending their expertise through daily practice and, right from the beginning of their careers, through CPD. Interestingly, in the focus group interviews, final year students and faculty did not speak of consolidation of clinical learning, begging the question whether this may be an

underdeveloped or insufficiently emphasised aspect of osteopathy programmes. A small number of New Registrants suggested that consolidation of clinical skills and patient management plans would have been welcome in the final months before graduation (see, for example, section 9.4 or third quotation in Figure 40).

Clinic and placement learning, and clinical assessments, were central to ensuring that osteopathy graduates were sufficiently well prepared to commence practice. However, there were concerns about the variability of clinic and placement education, both between and within OEs (section 4.6.1). Many health professions have steadily increased their use of simulation to augment placement learning over the past 20 years.⁴⁴ This trend has a number of drivers, including mitigating placement shortages and less than ideal experiences in clinical areas. Nursing in particular has grappled with the benefits and tensions of using simulated professional practice to augment experience in clinical settings.^{45,46} More general research into placement learning, termed 'work integrated learning' (WIL), has indicated that WIL influences students' development more if they experience several work environments.⁴⁷ OEs differed in the extent to which this was possible, but the general research supports the perspectives of those OEs which regarded the depth and variety of their programme's clinic experiences as a benchmark of excellence (section 4.6.1).

Study participants expressed concern about variability in clinical assessments (section 4.6.2) and noted the strong focus on clinical skills and safety, perhaps to the detriment of interpersonal skills and osteopathic reasoning. This has been echoed in the osteopathic literature, which documents substantial work to improve clinical assessments.^{48,49} It is difficult to assess clinical reasoning and interpersonal skills, so osteopathy is not alone in struggling to achieve this.^{50,51}

The wider health professions' literature considers pre-registration education cannot possibly create 'expert practitioners' (although experienced colleagues in practice settings often express a desire for novice practitioners to be more expert and, therefore, more easily integrated into the practice team). Nevertheless the aim of pre-registration education is to create practitioners who are 'fit for practice and purpose': that is new registrants with an adequate knowledge base for their area of practice, competence in a range of foundation level clinical skills, awareness of their role and its interactions with others, awareness of their limitations, patient-centeredness, professional attitudes and behaviours and a commitment to career-long learning.^{52,53} Novice practitioners need time, support and workplace experience to develop into expert practitioners.^{14,15,54,55}

Turning to borderline students, study participants reported that when students failed clinical assessments, if they remained on the programme, they received additional tutorial support. Some student focus group participants reported concerns that these failing students may be better served, and ultimately better prepared for practice, than those who passed by a narrow margin (see Figure 9). It may be valuable for OEI faculty to pay closer attention to the competences and confidence of borderline passing students, since a

graduate who has been persistently in this zone may be vulnerable in the transition to practice. Additional tutorial support or additional clinic experience may be appropriate. Perhaps borderline passing students could be given an option of participating in the additional clinical support which borderline failing students are expected to accept.

Novice practitioners can never be fully prepared for practice for a number of reasons. Firstly, practice is not static and not uniform, so there is no definable target for preparedness; although certain aspects of practice can be expected to be reasonably enduring and these can form the foundations of preparedness. Secondly, being fully prepared for practice with minimal need for additional learning or support, 'oven ready and self basting',²⁷ would imply that knowledge and expertise gained in one environment could be transferred and reused in the next environment. But transfer of learning is not that simple or complete, although some teaching and learning processes can promote transfer.^{56,57} Learning is not transferred without first being redeveloped in the new context.⁵⁸ Learning and workplace performance are situated in social contexts and develop through engagement in practice: aspects of the context support or inhibit newcomers' performance – even very simple administrative matters.^{25,39,42,59} Therefore performance is not an individual attribute but an interaction between the individual practitioner, the work context and the work activity. Indeed, Kilminster and colleagues argue that emphasis on preparedness is misplaced because it does not address the challenges inherent in transitions.⁶⁰ Instead, they argue it would be more productive to view transitions (at all levels of practice, not just for new entrants) as 'critically intensive learning periods' (CILPs), which are dependent on the particularities of each practice setting. It would be helpful if osteopathy graduates anticipated their transitions to practice (and from one work setting to another) as CILPs, during which, firstly, performance will be temporarily impaired by the need for context-specific learning which cannot be done in advance of entering that work environment and, secondly, that learning will be intensive (and performance should improve rapidly). OEs could have a role in developing realistic expectations and strategies for addressing learning needs during CILPs. It would be expedient for experienced osteopaths to examine the workplace culture and practical arrangements to examine whether small changes would better support newcomers (of whatever level of experience, but for the focus of this study, particularly New Registrants).

10.2.3 Clinical knowledge and skills

Two thirds of New Registrants reported knowledge of anatomy as an area of confidence, but beyond that, New Registrants reports of strengths and weaknesses in their knowledge and clinical skills were extremely variable (section 4.5.1). Almost every area of confidence named by a New Registrant was also named by another as an area of limited confidence (including anatomy). The variability will partly reflect the diversity of individuals, partly the range of knowledge and skills that feed into osteopathic practice and partly, slightly

different emphases between osteopathic degree programmes (sections 4.5.1, 4.5.2 and 9.4). Nevertheless there was consensus that osteopathy graduates' knowledge and skills were sufficient to safely commence independent practice (sections 10.2.1 and 10.2.2). The prevalence of isolated practice was the main rationale for osteopathy degrees' concentration on clinical knowledge and safe practice, but there was some concern about heavy concentration on knowledge and safety squeezing out other important areas of learning (section 4.6, Chapter 5 and Chapter 6). As we noted in the previous section, clinic and placement learning experiences were variable and there were some concerns about the variability of clinical assessments. A high proportion of New Registrants engaged with CPD, even during the first year of practice when current CPD regulations¹⁸ do not require this (section 7.5.1). The main motivations for this early engagement were to plug knowledge or skill gaps, extend the New Registrants' repertoire and to build confidence. An adequate knowledge base is certainly essential for sound clinical reasoning⁶¹ and experienced osteopaths were complimentary about new graduates' knowledge, although New Registrants had reservations about keeping their knowledge up to date without affordable access to a sufficiently wide range of online bibliographic resources (section 7.4.2).

As we noted in the previous section, there were suggestions that osteopathy students would benefit from greater attention to the consolidation of clinical skills during the final year of degree programmes. Many health professions' degrees devote much of the final year to clinical practice and some make particular efforts to ensure that patient contact is sufficiently lengthy that students can see the consequences of their earlier clinical decisions, reassess and update management plans. For example some Speech and Language Therapy courses require final year students to carry a small caseload throughout the year, seeing these patients at follow-up appointments. Similarly, midwifery programmes encourage longitudinal practice experiences to complement gaining experiences at each stage of the antenatal to postnatal journey.⁶² The data collected for this study did not contain any mention of attempting to provide longitudinal practice experiences. This was interesting because Colleagues and Employers suggested that osteopathy graduates needed a better appreciation of the recovery process and complexity in patients' conditions and circumstances (section 4.5.2); appreciation of these things may be more easily obtained from longitudinal practice experiences than 'snapshots' of disconnected practice.

From the patient perspective, the OPEn study¹ identified explicit and effective triage at the first appointment, and where necessary referral to a different practitioner, as a priority for development across the osteopathic profession. The main way in which triage appeared in the data for this study was in relation to safety: particularly the identification of 'red flags' requiring medical investigation. A small number of respondents to the Colleagues' and Employers' survey suggested that New Registrants should more readily refer patients on to a more experienced osteopath or to a different type of practitioner. This highlights that triage is about more than safety. It is linked to the clinical insight required to appreciate that the most effective way to help some patients is to refer on, rather than treat; combined

with the professionalism to act on this insight. Through this process, small individual business losses could safeguard or even improve the reputation and popularity of osteopathy. There was no evidence in the data for this study that New Registrants failed to refer on, when they recognised this as appropriate; just a small number of suggestions that they did not always immediately recognise that they were unlikely to be able to succeed in helping certain patients through their own interventions.

10.2.4 Interpersonal and communication skills

Well-developed interpersonal and communication skills are just as central to osteopathic practice as clinical knowledge and treatment techniques. In general, study participants felt that osteopathy graduates' interpersonal and communication skills were less well developed than their clinical knowledge and skills (Chapter 5). Curriculum provision focused on developing interpersonal and communication skills varied between osteopathy programmes and some faculty were candid that this was an area of weakness (section 5.5). It was fairly commonly reported that faculty felt ill-prepared to address students' interpersonal and communication skills, although they did provide specific teaching relating to communicating with other healthcare professionals and medico-legal matters, for example. Some OEs were addressing faculty development needs in this area and several OEs mitigated limitations in faculty expertise by inviting medico-legal experts, counsellors or psychologists to provide guest lectures or workshops. These were well received, but could feel like bolt-on extras rather than integral parts of a systematic curriculum thread addressing interpersonal and communication skills. This study received no reports of these experts being invited to provide faculty development for the programme team, particularly clinic tutors.

In general, it was hoped that interpersonal skills development would arise naturally from engagement in clinic and placement learning: some students termed this 'learning by osmosis'. However the role modelling from clinic tutors was reported as extremely variable: from excellent to awful (sections 5.5.2). Even in better situations, the emphasis on communication skills seemed to be geared more towards supporting diagnosis, treatment and requirements for formal communications, rather than interpersonal skills for patient management. Most attention focused on pragmatic clinical matters, such as how best to elicit information whilst taking case histories, and formal communication between professionals, including legal processes. Humanism and the communication aspects of patient safety were more lightly touched upon. There were concerns that too much was being left to chance, if preparation for challenging situations was reliant on students chancing upon a challenging situation in clinic at the same time as being lucky enough to be supported by a skilful tutor to provide a good role model and then support reflection to guide the students' development. We received no reports of OEs making use of simulation to support this aspect of students' learning.

Simulation is an umbrella term for a wide range of pedagogic practices such as role play, use of 'part-task trainers' to develop psychomotor skills, use of professional actors as simulated patients, recreation of simulated work environments, complex scenario-based simulations for (often multidisciplinary) teams, use of virtual reality, unfolding case studies and even business games. Educators have to choose the appropriate style of simulation to support particular learning objectives and, for economy, should select the lowest fidelity simulation that meets pedagogic needs. Simulation is best suited to situations when there is an educational advantage if time can be accelerated or slowed down and levels of complexity can be controlled to match and slightly stretch participants' expertise. Simulation is useful when it would be too costly or dangerous to allow learning from experience.⁶³ The styles of simulation that might be particularly well-suited to developing interpersonal and communication skills include scenario-based simulations addressing interprofessional collaboration⁶⁴⁻⁶⁷ and the use of specially trained professional actors as simulated patients to help rehearse responses to challenging clinical situations.⁶⁸⁻⁷⁰ Many health professions use simulated patients to support key aspects of learning, particularly rehearsal for challenging situations and assessment via simulated healthcare interactions. Healthcare programmes may build and maintain a programme-specific bank of simulated patients or draw trained actors (who will still require some programme-specific briefing) from agencies that specialise in supplying simulated patients.

We noted earlier (section 10.2.1), that the assessment of interpersonal skills was downgraded in favour of an emphasis on clinical safety. Interpersonal skills are difficult to define and assess and much work has been conducted by other healthcare professions to begin to address this knotty problem,^{51,71-79} although we should be wary of sacrificing authenticity in a pursuit of objectivity.⁸⁰ Interpersonal skills can be overlooked because they are ephemeral⁸¹ or not specified in assessment schedules,⁸² but poor interpersonal skills during pre-registration education are predictive of later professional disciplinary action.⁸³ Instruments such as the Interpersonal Skills Profile,^{78,79,84} for example, are simple to use for formative and summative assessments and have been adapted for use by different professions.

New Registrants felt well-prepared for teamwork, making appropriate referrals or relaying advice on future treatment, and managing conflict; but less well-prepared for consulting other professionals; while some recognised initial mistakes in communicating a more optimistic prognosis than was warranted (section 5.4). A small number of New Registrants struggled to explain potential risks without "*frightening*" patients and straining the therapeutic relationship (section 7.3.2). Students expressed concerns about their preparedness to practice with respect to patients with support needs related to mental health or mental capacity. Some OEIs had begun to explore ways to meet these learning needs, but, provision was patchy. Employers and Colleagues regarded New Registrants as well prepared for taking case histories and record keeping; reasonably well prepared for explaining diagnoses and treatment options to patients, and communication with direct

colleagues; but less well prepared for challenging situations with patients or responding to patients anxieties, encouraging self-care, communicating a realistic prognosis, communication with other professionals and appreciating the role of interpersonal skills in building a patient base (section 5.3). Overall New Registrants rated their interpersonal and communication skills more highly than the ratings of colleagues and employers, which was consistent with other research showing self-rating of interpersonal skills to be higher than third party ratings.^{85,86}

Since osteopathy is often a second or subsequent career, many osteopathy students could have relevant prior learning or experience to inform teaching and learning about interpersonal and communication skills; for example mental health nursing, counselling qualifications or a former role in a complaints department. However, this study received no reports of faculty encouraging peer learning from members of the cohort with relevant expertise from earlier careers; sometimes to the frustration of students.

The OPEn study¹ made multiple recommendations for development priorities across the osteopathic profession, which fall in the area of interpersonal skills and communication, viz: better support for patients' individual agency through better provision of information and advice in relation to the patient's problem and ways to prevent recurrence; providing pre-attendance information about the nature of treatment and likely after-effects; providing information about risks and side-effects and how to make a complaint; providing reassurance about confidentiality and about levels of pain during treatment. Patients also wanted osteopaths to treat one patient at a time. These recommendations were published after the data collection for this study was underway, so these points were not specifically probed, although they should now be considered during osteopathic degrees. The data from this study indicated that New Registrants may overlook advice about ways to prevent recurrence of problems (section 4.5.2), could sometimes be over-zealous or clumsy about enumerating risks (section 7.3.2) and were developing their expertise in relation to communicating likely after-effects (section 5.4). During the early months of practice New Registrants increased their understanding of the importance of providing a good patient experience (section 6.4). Their perceptions about the facets of providing a good patient experience were in tune with the OPEn study recommendations and most often included interpersonal skills such as building a good rapport, providing ample explanation, maintaining a professional manner and putting patients at ease.

It was clear that New Registrants' interpersonal and communications skills development had continued in the early months of practice, which once again speaks to the point made in section 10.2.2 that some learning has to occur through engagement in the workplace because learning and performance are inseparable from work itself.^{58,60} For example, several New Registrants indicated that, having initially been prone to over-optimism, they were developing ways of communicating more realistic assessments of what osteopathy might achieve, and how long and difficult the process might be. Nevertheless some of this learning could also occur during consolidation of clinical practice during the final months of osteopathy degrees and whenever there are opportunities for longitudinal practice

experiences. In addition, New Registrants provided a diverse range of examples of situations in which their interpersonal and communication skills had served them well, and similarly, situations when they felt they needed better interpersonal and communication skills. Recurrent themes were summarised in section 5.4 and these could help guide curriculum development and postgraduate support.

10.2.5 Entrepreneurial and business skills

In Chapter 6 we saw there was consensus among stakeholder groups that New Registrants were less well prepared for the entrepreneurial and business aspects of osteopathic practice than for clinical or interpersonal aspects (and some initially lacked appreciation of the impact of interpersonal skills on business success). Primarily, osteopathy students wanted to develop clinical knowledge and expertise to realise their ambition of becoming osteopaths. They did not always value business-related learning until the final months of degree courses and then realised that it was too late to cram everything in. Among faculty there was much discussion about ways to support learning about business and entrepreneurship: different OEs had different approaches, but there was widespread debate about identifying the optimum timing, and achieving the correct focus and level for different years of the course. It is understandable that students wanted to focus mainly on clinical matters: how could they envisage building an osteopathic business if they had not developed the skills to treat patients? Therefore one approach to the problem of 'readiness to learn'⁸⁷ about business related matters could be to integrate business learning as fully as possible with clinical learning. For example, colleagues and employers felt that New Registrants needed better presentation skills to promote their services (section 6.3). Although the genre of a clinical case presentation is a little different from a promotional presentation, overt links could be made from case presentations to other contexts in which good quality presentations will be necessary. Transferable elements of presentation skills could be highlighted. Similarly, when students gain clinic and placement experiences their attention could be directed towards the day-to-day management of clinics, the promotion of services to the public and other healthcare providers, workplace etiquette and collaboration, interprofessional communication and collaboration. Some OEs were already doing some of these things and there are many more possibilities.

Whilst reminding ourselves of previous discussion that students can never be fully prepared for the transition to practice (section 10.2.2), it is still worth noting that Colleagues and Employers perceived that New Registrants had unrealistic expectations about effort and difficulties in building and maintaining an osteopathic business. Perhaps this perception was accentuated by the timing of this study, during a period of worsening economic conditions which was also causing some reduction in business for established osteopaths. Nevertheless, if some aspects of OEI provision may contribute to unrealistically optimistic expectations, it could ease transitions to practice to try and better align expectations with

predictable aspects of practice, such as the importance of word of mouth recommendations and how the patient experience will affect these: even though we noted in section 6.4 that students may not fully appreciate these messages until they gain first-hand experience.

Although study participants identified a few opportunities to give students first-hand experience of reasonably authentic business activities, such as marketing the in-house clinic or contributing to clinic administration, these cannot mirror the demands of building one's own patient list. Therefore, it would also be helpful to engender realistic expectations that much of the detail of establishing and maintaining a business cannot be taught in advance, partly because market conditions and details of regulations change rapidly, but mainly because such learning is situated and can only be learnt through engagement with the activities of establishing a business.^{39,40,59} It is inevitable that setting up an osteopathy business or building one's own patient list within a group practice will be a 'critically intensive leaning period'⁶⁰ (CILP). During CILPs it is difficult for practitioners (and perhaps particularly novice practitioners such as New Registrants) to perform to the best of their abilities and assistance from colleagues and others would be most welcome.

It is unfortunate for osteopathy graduates that the CILP related to commencing autonomous clinical practice (section 10.2.2) coincides with the CILP related to developing a viable business. This is unusual for many healthcare professions whose novice practitioners mainly build clinical, interpersonal and management expertise in team-based care with a certain amount of supervision before commencing independent private practice. This is the origin of many New Registrants' expressed preference for commencing practice as an associate in a group practice and the advice from many experienced osteopaths that New Registrants should begin their careers in group practices (section 8.7). However, this not practical for everyone because the number of osteopathy graduates is projected to grow and already outstrips the number of associate positions (not currently projected to grow, due to economic conditions). New Registrants' undoubtedly need business advice and support, particularly if they are trying to establish themselves as lone practitioners, and perhaps there is scope for local, regional and national osteopathic networks to increase their contributions to this. In addition it should be remembered that local, regional and national *business* networks are also an important source of advice and support. Several New Registrants were accessing generic business advice and participating in generic business networks, which they found very useful; many had found free or low-cost sources of advice and networking opportunities. Perhaps one aspect of preparation for practice is to raise awareness of multiple routes for securing necessary support and networking. Providing opportunities for senior students to network with relatively recent graduates might be helpful in this respect.

Osteopaths are not alone in experiencing the double CILPs of commencing clinical practice and developing a business. This experience is shared with a wide range of complementary therapists and other wellbeing professionals. There could be value in greater exploration of

how members of these professional groups provide or draw in support for novice practitioners.

As we mentioned in relation to interpersonal skills (section 10.2.5), osteopathy programmes attract many mature students some of whom have earlier career experiences which mean that they have pertinent insights or expertise which, with adequate faculty facilitation, could be harnessed to support the learning of the whole cohort.

An osteopathy business will not survive (and may harm the profession more generally) if the quality of osteopathic care is not good, so any increase in attention to entrepreneurial and business skills needs to be fully integrated with the main curriculum focus of developing sound clinical expertise and high quality patient experiences.

Despite many criticisms of New Registrants' entrepreneurial and business naivety, there was also appreciation from Colleagues and Employers of the value of their enthusiasm and new ideas.

10.2.5.1 Preparedness not to practise as an osteopath

This study was commissioned to examine osteopathy graduates' preparedness to practise as osteopaths. The data collection and analysis remained true to this brief, but a little consideration of preparedness not to practise as an osteopath is warranted. Study participants appeared to have a working assumption that all osteopathy graduates would become osteopaths, which naturally led to concerns about supply and demand: but why? We would not expect all five-year Master of Engineering graduates to become engineers, although many will, but those degrees offer the foundations for a range of careers. Similarly we do not expect all law graduates to become lawyers or all veterinary science graduates to become vets. Due to investments of very substantial sums of public money, the UK governments do restrict university places for many health professions and also teachers, by making workforce planning projections. However workforce planning is a very imprecise art, beset by many fluctuating variables.⁸⁸ The acute and continuing shortage of NHS midwives is one example of this.⁸⁹ Osteopathy is a profession with ambitions to expand. Expansion of *good quality* osteopathy services has the potential to make a bigger impression on the public psyche and influence commissioning of osteopathy services by large organisations. Workforce planning is neither practical nor appropriate for osteopathy. However, the quality of graduates' preparedness to practise must be maintained to ensure that the increasing number of practising osteopaths consistently offer high quality care. In addition, OEs must consider and support preparedness for other careers, for those for whom it becomes apparent that osteopathy will not become their career.

10.2.6 Professionalism

Professionalism is a complex and diffuse concept. It does not stand aside from other aspects of expertise, but rather infuses these with values, attitudes and actions that are patient-centred and empowering, collaborative, ethical, self-aware and aligned with osteopathic values and principles. Consequently aspects of professionalism have already appeared in this discussion: clinical education's emphases on safety and communication with patients (sections 10.2.1 and 10.2.4); preparedness for collaboration with other healthcare professionals (section 10.2.4); the interplay between professional behaviours and building a successful osteopathic business (sections 10.2.4 and 10.2.5). Chapter 7 summarised data pertaining to additional aspects of professionalism, viz: standards for practice, osteopathic values, evidence-based practice, continuing professional development, reflective practice and self-evaluation.

There was consensus that osteopathy graduates were conversant with Standards for Practice and that these infused learning, teaching and assessments, thereby embedding a sense of professional behaviour in students from the earliest stages of their programmes. This is important because unprofessional behaviour during professional education is a predictor of disciplinary action in later practice.⁸³

There was consensus that osteopathy graduates understood the principles of evidence-based practice. However there were concerns about keeping up to date without affordable access to bibliographic materials, osteopathic evidence for practice was thought to be in short supply and the nature of evidence for osteopathic practice was contested. Study participants reported that the physiotherapy literature was a useful source of evidence for certain aspects of osteopathy.

A small number of study participants expressed frustration with the medical model of evidence-based medicine (EBM) as it is now practised, but it is worth noting that the landmark definition of EBM by Sackett and colleagues in 1996,³³ described it as "*the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients*" (p71). It is often forgotten that they saw EBM as still evolving; as *integrating* individual clinical expertise with externally produced evidence and as enhancing professional expertise. They argued that EBM was not then widely practised; was not unachievable idealism; did not diminish the importance of the individual; was not necessarily cost cutting; and was not restricted to randomized trials and meta-analyses. This guiding view of EBM is compatible with osteopathic ideals.

A small number of study participants noted that, contrary to the rhetoric of evidence-based practice, NHS healthcare practitioners and services are often slow to integrate new evidence in daily practice, which has been noted by others.^{90,91} There is a substantial body of research that explores the diffusion of new knowledge and its gradual integration within practice,⁹²⁻⁹⁶ including in other holistic professions where the nature of evidence for practice is contested, such as occupational therapy.⁹⁷⁻¹⁰¹

Perceived resistance to EBP has been noted in the osteopathic literature and linked to perceived resistance to critical thinking among osteopathy educators and practitioners.¹⁰² However, this was not identified in this study, with the participating OEI's working to promote critical thinking and EBP. In some cases they reported using resistance from some practitioners as a mechanism for development of critical thinking. Very few survey responses from practising osteopaths were critical of EBP (sections 7.4.1 and 7.4.2) but experienced osteopaths regarded New Registrants' critical thinking as only partially developed (section 4.5.2).

There was no consensus about osteopathic values. The diversity of perspectives linked to two emergent cross-cutting themes: Diversity, Variability and Uncertainty (section 9.4) and Autonomy and Isolation (section 9.5). Study participants reported that, while there are some common threads, OEIs have developed subtly different values and positions about what osteopathy is as a set of practices, which influences the educational ethos. This was also noted by Sommerfield who discussed the tensions and responsibilities of osteopathic educators in enabling an osteopathic identity when confronted with a variety of individual and social interests.¹⁰³ Indeed Tyreman argued that values are often communicated to learners inadvertently without being subject to any scrutiny or debate, and proposed that the values of OEI's should be explicit and transparent.¹⁰⁴ The diversity and uncertainty detected in this study made it more complex for osteopathy graduates to be well prepared for practice.

Professionalism involves self-monitoring of strengths and weaknesses and a career-long commitment to continuing learning. The great majority of respondents to the New Registrants' Survey were confident that they could recognise their strengths and weaknesses, although data from the Colleagues' and Employers' survey highlighted variability, which is consistent with other research that shows healthcare professionals find it difficult to calibrate their own strengths and weaknesses.^{85,105} Within OEIs the main activity associated with self-evaluation and commitment to career-long learning was the promotion of reflective practice, although this had a relatively short history at some OEIs. There were some reports of faculty and students struggling with the processes of reflection, although others were very positive. An initial struggle with the concept and processes of reflective practices is not unusual. It helps to have a clear rationale and focus for reflective activities. Providing a variety of models to support reflection can also help accommodate individual preferences.¹⁰⁶⁻¹¹⁰ Since reflection cannot overcome all human difficulties in self-assessment it is important for students to receive good quality feedback throughout their degree programmes and to develop a habit of seeking and valuing third party feedback. Once in practice, seeking feedback from colleagues and patients will be important.

Professionalism requires that, working hand in hand with reflection leading to realistic self-evaluations, practitioners engage in career-long learning to update, refine and expand their expertise. This study found high rates of participation in CPD, even among those in their first post-degree year and, therefore, exempt from GOSc CPD requirements.¹⁸ However,

continual reading is a central aspect of professional updating and we have already noted New Registrants' concerns about insufficient affordable access to up to date published research (despite GOsC funded access to a range of research journals though the **o zone** web site).

Autonomy emerged as a defining feature of osteopathic professionalism. This will be discussed in section 10.2.8.

10.2.7 Diversity, Variability and Uncertainty

There was marked diversity, variability and uncertainty at all stages of osteopaths' development from students to competent practitioners. Student cohorts could be very mixed, with a large proportion of mature students with diverse past careers and life experiences. Faculty sometimes struggled to match the curriculum to everyone's needs (sections 5.5 and 6.5). Clinic and placement education varied between OEIs and, even within each OEI; formative feedback and role modelling varied from excellent to awful and clinical assessments were regarded as somewhat variable (section 4.6). Lack of consistency in clinic learning, feedback and assessment was highlighted by both faculty and students (section 4.6). Variation in clinical assessments is a difficulty faced by several professions. Medicine, in particular, has embraced multiple mini-assessments and the use of simulation to try to reduce the influence of variation in clinical assessments.¹¹¹⁻¹¹⁸ In this study there was noticeable variation in the clinic opportunities that each OEI could offer and the extent to which students participated in all aspects of running the in-house clinic. Students had some concerns over the range of techniques taught and recommended by different tutors to address similar symptoms. Partly this was confusing when students were faced with deciding what to do; partly it inhibited practise and consolidation of a more limited range of skills. Students were also concerned about variation in the amount of support offered to individual students, particularly between those who passed assessments by a narrow margin and those who failed assessments by a narrow margin.

Following graduation, employment prospects may be to some degree segmented by perceptions of subtly different profiles of expertise related to differing emphases within OEI programmes (section 7.3.3). More widely, experiences of employment conditions, mentorship and other support during the early months of practice were extremely variable (Chapter 8). Some New Registrants felt well-prepared and well-supported while others had much more difficult experiences. Mentorship was predominantly provided by practice principals and faculty from the New Registrant's former OEI, but New Registrants also sought and received mentorship from a variety of other sources such as CPD groups, peers and family. Many mentorship arrangements were informal and some New Registrants were very uncertain about what they could reasonably expect. There were some reports of unequal access to CPD and mentorship, based on geographical isolation. However, there

were more responses that focused on the variable quality of CPD and the uncertainty this created when selecting CPD courses.

It was impossible to identify a 'typical' trajectory for a new Registrant, perhaps apart from reality shock in relation to the long and arduous process of building a patient base. Reality shock is a gap between expectations and the realities of commencing work in a new environment, which influences retention of practitioners¹¹⁹⁻¹²¹ and leads to restructuring of perceptions of professional knowledge and practice.¹²²⁻¹²⁶

Nevertheless diversity was prized as a facet of autonomy.

10.2.8 Autonomy and isolation

The construct of being autonomous emerged out of the data as multi-faceted; encompassing professional behaviour, the extent to which new registrants and learners are developed as autonomous practitioners, and managing the various levels of isolation osteopaths experience in clinical practice. Autonomy was very important to the study participants and had slightly contradictory strands (section 9.5). Autonomy was prized in its own right, but was also imposed by commercial necessity. Independent, possibly isolated, practice was the only option for many, which placed a premium within osteopathy degrees on learning for safe, self-directed practice. The high value placed on autonomy could make it difficult for practitioners to ask for help or advice. Many New Registrants, including those working within group practices expressed a sense of isolation during their early months of practice. Through this socialisation, osteopaths become accustomed to exercising significant levels of autonomy: it becomes part of their identity. The centrality of autonomy to professional identity can then be challenging if new profession-wide policies are considered. While autonomous practice has long been a marker of professional status¹²⁷ the data from this study indicated that autonomy is a particularly complex construct in osteopathy: one that influences preparedness to practise and wider development of the profession.

10.3 Mechanisms that support, or could support, New Registrants' transitions to successful practice as an osteopath

10.3.1 Attention to the role of undergraduate clinic- and placement-based learning

Earlier sections have drawn attention to the importance of clinic and placement learning, and concerns about its variability (sections 10.2.2 and 10.2.7); additional scope to prioritise consolidation of clinical skills and engender the development of interpersonal skills and business acumen through the medium of clinic and placement learning (sections 10.2.2, 10.2.4 and 10.2.5) and concerns about formative and summative assessments (section 10.2.2). Respondents to the Colleagues' and Employers' survey made a wide range of

suggestions about ways in which pre-qualification clinical education could be strengthened to ease graduates' transitions into practice: many of these centred on perceived benefits of increasing the proportion of practice learning conducted outside in-house OEI clinics (section 8.3). Some external practice placements beneficially provided experience of interprofessional collaboration.

Practice-based learning is central to all health professions' education.¹²⁸⁻¹³⁴ For example it occupies 50% of nursing programmes and 60% of midwifery programmes. By the final year of nursing programmes students are no longer supernumerary visitors to a clinical area, but rostered members of the care team. Medical students have no long vacations for the final two years of their degrees and spend several months in clinical 'rotations'. Speech and Language therapy students carry a small case load during their final year. Dental students work in outreach community clinics as well as hospital clinics. There are many models of clinic and placement-based learning¹³⁵ which might be explored for elements that would fit and enhance osteopathy education.

10.3.2 Mentorship

In Chapter 8 (section 8.4) we saw that over two thirds (68%) of the respondents to the New Registrants' Survey had received mentorship or less formal support from a more experienced osteopath, although nearly a fifth (19%) had sought this but found it unavailable. Most (82%) of the respondents to the Colleagues' and Employers' Survey mentored New Registrants. The two groups reported similar experiences: arrangements varied widely and were often ad hoc. Approaches included close and proactive supervision; reactive help upon request, with varying degrees of availability and input; or total isolation. Some respondents thought it was important for New Registrants to be proactive and ask for help; some also mentioning self-assessment, reflective practice and commitment to improvement, which links to aspects of professionalism (section 10.2.6). The focus of mentorship tended to lie with immediate support needs, rather than systematic development of New Registrants' practice, and with clinical matters much more than practice management or business development.

New Registrants sought and received mentorship from many sources, most often practice principals, immediate colleagues and former OEI tutors. Family and friends were also identified as sources of mentorship and encouragement. This echoes the wider literature. For example, across a range of university disciplines and business sectors, mentorship and moral support from family and friends was found to influence the success of transitions from university to entrepreneurship: in addition to work placements, informal advice from tutors, mentorship in university 'business incubators' and curriculum content focused on entrepreneurship.¹²⁶ Within health, friendships have been found to support students' learning during clinical placements.¹³⁶

In principle, nearly all study participants from all stakeholder groups supported more extensive and more formal mentorship for New Registrants, but resource requirements were thought to be insurmountable. Sustainability and quality were the primary concerns of study participants in relation to any extension of mentorship. Discussions highlighted the need to clarify mentorship requirements, mentor support needs, mentors' remuneration or other recognition (such as CPD points) and the need to monitor the quality of mentorship. It was recognised that any strategic development of the profession's use of mentorship would require partnership working between the GOsC, BOA, OEs and the community of practising osteopaths. However, some worried about oppressive oversight, loss of autonomy and increased potential for exploitation if the profession moved towards more formal mentorship. The creation of local networks and 'hub and spoke' approaches as informal processes were the favoured options: on cost grounds and due to their voluntary nature.

Concerns about mentorship capacity related to an upward trajectory in the number of osteopathic graduates. However, the Colleagues' and Employers' survey (section 3.4) demonstrated that most mentors in group practices work alongside only one New Registrant, which would not appear to be an excessive mentorship load. However, experienced osteopaths may also be involved in providing mentorship for New Registrants who practise alone, stretching mentorship resources further. Any formalisation of mentorship would require adequate arrangements for those practising alone and in geographically remote locations. Other expanding professions have become concerned about providing sufficient mentors and ensuring adequate quality. For example, the paramedic profession in Australia has strengthened its pre-qualification education to include competencies relating to mentoring, teaching and development of others.¹³⁷ Paramedics share with osteopathy a prevalence of isolated practice, their work mainly being conducted in pairs when out with an ambulance or, increasingly, lone first-responder work. Rapid expansion in the profession meant that there were too few experienced practitioners to supervise and mentor novice practitioners and students, so rather junior practitioners were undertaking preceptor (mentor) roles.¹³⁸ Pre-qualification preparation for mentor and clinical educator roles also occurs in nursing curricula and some medical curricula.¹³⁹ The osteopathic profession may wish to debate the value of introducing preparation for educator and mentor roles within osteopathy degrees: this could develop knowledge and skills which would support the next generation of osteopaths, but also help develop a culture of mentorship and educational facilitation as integral to professional practice.

In this study, several respondents suggested that CPD credit would be provided appropriate recognition of mentors' efforts (amounting to a reduction in CPD requirements). This is an interesting perspective. Clearly any CPD to enhance mentorship expertise, or any learning arising from the mentor's involvement in the mentorship process, including individual or co-operative study and reflection, would gain credit under the current CPD scheme. However, suggestions about reducing CPD requirements in exchange for time spent in mentorship

seemed to mainly be viewed as compensation for mentorship rather than an educational argument that mentorship necessarily promotes the mentors' learning and ought to be recognised routinely within the CPD framework. This position suggests that experienced osteopaths need extrinsic motivation to engage in mentorship, but this study found that many experienced osteopaths enjoyed (intrinsic motivation) working with New Registrants (section 4.3.1). Some experienced osteopaths made comments that indicated the presence of 'expansive' learning environments.^{25,26} These are environments where new practitioners are not simply required to fit in and learn about how things are done, drawing from the expertise of more experienced colleagues (however supportive), but the newcomers are also recognised as bringing new knowledge and ideas from which colleagues can benefit and through which workplace practices can evolve: the learning of the whole workplace expands. On the other hand some experienced osteopaths preferred New Registrant colleagues to have very few support needs, in essence to be 'oven ready and self-basting',²⁷ or simply found that the support needs of less skilled New Registrants' exceeded their capacity to provide support. This is a difficult area: experienced osteopaths have limited time for mentorship and cannot be expected to compensate for severe deficiencies in pre-qualification education. However, philosophers and professions have long argued that those who benefit from professional registration also have reciprocal duties to the profession, for example, in the sixteenth century Francis Bacon stated:

"I hold every man (sic) a debtor to his profession; from which as men of course do seek to receive countenance and profit, so ought they of duty to endeavour themselves, by way of amends, to be a help and ornament thereunto." (Bacon, *Maxims of the Law*, preface)¹⁴⁰

Professional social pressure to provide mentorship is strong in many professions. For example The General Medical Council states:

"Teaching, training, appraising and assessing doctors and students are important for the care of patients now and in the future. You should be willing to contribute to these activities." (*Good Medical Practice*, 2009, p14)¹⁴¹

Furthermore revisions proposed during 2012 are likely to strengthen social pressure for all doctors to seek and provide mentorship:

*"- You should seek out a mentor during your first years working as a doctor and whenever your role changes significantly throughout your career.
- You should be prepared to act as a mentor to less experienced colleagues and to contribute to teaching and training doctors and students."*
(*Good Medical Practice 2012 Consultation*, p14)¹⁴²

Harnessing social pressure also lies behind many patient safety campaigns¹⁴³⁻¹⁴⁴ and the current interest in 'positive deviance'¹⁴⁵⁻¹⁴⁷ as a way to improve the quality of health care. Good quality, intrinsically satisfying mentorship in osteopathic practice could be framed as positive deviance and used to promote more and better quality mentorship across the profession.

Using a variety of terms for such roles and processes, many health professions have developed (to a greater or lesser extent) mentor, preceptor, supervisor and practice-based assessor roles to support novice practitioners' transitions to professional practice.¹³⁵ Training for mentorship roles is considered important.^{14,148-150}

In this study mentorship was the most widely practised and extensively discussed mechanism for supporting New Registrants (section 8.4). This was seen as the least controversial approach to supporting the early-stage needs of new registrants and there was widespread support, in principle, for increasing the proportion of new registrants who receive mentorship; although a very small number of study participants viewed this as the wrong approach, considering that any deficiencies in preparedness to practise should be addressed through pre-qualification education. More widely shared concerns about extending the provision of mentorship centred on resources, training and monitoring requirements.

10.3.3 Conditional registration or supported foundation period

For some study participants, a sense of urgency to improve the extent and quality of mentorship for new graduates extended into support for the idea of a “*pre-registration year*” of supervised practice. However, others felt strongly that new graduates are deemed safe to practise, do not require further scrutiny and should be allowed to practise autonomously. This shows that the idea of ‘*pre-registration year*’ implies some form of assessment to confirm suitability for registration. Most of this study’s participants felt that resource constraints would be insurmountable, rendering the notion of a pre-registration year a hypothetical debate in osteopathy. This highlights assumptions of substantial commitments to support and assessments, practitioners and a concern for quality. There was greater support for a more structured and supported foundation period, during the early months of practice as an osteopath (section 8.5). We did not probe whether advocates literally meant 12 months supervision or simply a significant period of support. One study participant drew attention to the possibility of conditional registration: this would amount to a transition phase between academic qualification and a full recognition of independent practitioner status.

Novice professionals do need to restructure and extend their academic knowledge through participation in workplace practices, which can be a challenging experience for many months; particularly if expectations are not reasonably well-aligned with reality, support is elusive, expectations of the novice practitioner are unclear or inconsistent, it is difficult for the new practitioner to influence workplace decisions or processes, or the new work role makes it difficult to sustain a reasonable work-life balance.^{121,124,125,151} In nursing it has been suggested that a successful transition to the workplace takes up to 18 months.^{119,121}

Many health professions have pre-registration periods or supported foundation periods to ease the transition from pre-qualification education to the workplace. These vary greatly in length and formality. For example midwifery, nursing and a range of allied health professions, including physiotherapy, have a short period of preceptorship¹⁴ for new registrants and a tradition of clinical supervision to support the ongoing professional development of qualified practitioners.¹⁵²⁻¹⁵⁴ For nurses the preceptorship period is very short (often as little as four months). Preceptorship is defined as follows and mainly relies on formative workplace assessments by preceptors (mentors):

“A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor[qualified practitioner], to develop their (sic) confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning” (Department of Health, 2010, p11)¹⁴

Clinical supervision is a similar activity, which occurs throughout careers, once the period of structured transition for newly qualified practitioners has been completed.¹⁵²

Medicine encourages strong supervision and mandates multiple practice-based assessments of junior doctors during the first two years of medical practice, known as the Foundation Programme.¹⁵ The medical mentor-assessor roles (two levels, normally termed clinical educators and clinical supervisors) are held by consultant-level doctors and require them to prepare for the roles through engagement with a competency-based CPD framework.¹⁴⁹⁻¹⁵⁵

Some health professions require completion of an assessed pre-registration period of clinical practice in a training position, following the completion of a recognised university degree; for example health psychology (two years),¹⁵⁶ optometry (up to 27 months),¹⁶ pharmacy (one year)¹⁷ and, moving outside human health care for a model that may be useful in osteopathy, veterinary practice (approximately one year; also used as a return to work programme and for practitioners moving to a different speciality).¹⁵⁷ In contrast, Osteopathy has not promoted preceptorship or clinical supervision for qualified practitioners, and there are no formal postgraduate assessments for New Registrants unless they choose to undertake additional postgraduate training relating to specific areas of practice. Nevertheless, many osteopaths participate in informal mentorship and clinical supervision and New Registrants must comply with CPD requirements, at the latest ten months after joining the professional Register or within 14 months of graduation, whichever is sooner.¹⁸

As we saw in section 10.2, being prepared for practice in order to graduate is one thing, rather like passing one's driving test. Once driving alone and in new situations, a different quality and intensity of learning occurs. In osteopathic terms the question appears to be whether New Registrants need to be wearing 'probationer' plates for a while, and with what guidance, until they have the full freedom of the open road.

10.3.4 Early engagement with CPD

Early engagement with CPD was anticipated by final year students (section 4.3.2) and reported by the majority of new Registrants (section 7.5.1). The motivations identified in this study included identification of gaps in knowledge, a desire to expand knowledge and one's repertoire of skills, and above all, building confidence (section 8.6). It has been suggested that novice practitioners experience a sense of bereavement when they leave behind the structure and temporal flow of their degree programmes.¹²¹ In the absence of structured mentorship or a structured foundation period, and with high levels of isolated practice, interest in early engagement with CPD may also represent a way of returning to the type of structure, security and social support found during pre-qualification education.

10.3.5 Working in group practices and multidisciplinary environments

Working in group practices and multidisciplinary environments was thought to confer several advantages for students and New Registrants (section 8.7). This chimes with sociocultural theories of learning, in which new entrants join communities of practice^{59,158,159} and gradually build their expertise and context-specific competences through increasing engagement with work practices. At present in osteopathy, there are insufficient opportunities for new entrants to work in well-functioning communities of practice. Although there may be some scope for increasing the number of communities of practice in which new entrants may participate, for example by encouraging local networks, online communities and more placement opportunities; it appears that there is also a need to improve the quality of mentorship and workplace learning in some existing communities of practice.

Even within communities of practice, individual agency is important.⁴² In osteopathy an unusually high level of individual agency is required from most new entrants to overcome the isolation of their professional practice and to build a successful business. A degree of cultural change across the profession, to provide more proactive mentorship for new entrants would ease new entrants' transitions to practice; as could efforts during pre-qualification education to better manage expectations and develop resilience.

In this study, group practices and multidisciplinary environments, particularly busy ones, were thought to be ideal for building clinical experience *quickly*, which was thought to be important to protect New Registrants' knowledge, skills and confidence from ebbing away. This chimes with the notion of transitions between university and work environments, and between different work environments, as Critically Intensive Learning periods (CILPs) (sections 10.2.2 and 10.2.5);⁶⁰ during which the performance of the newcomer is likely to be impaired by the need for context-based learning.¹⁶⁰ The term CILP draws its idea of critical

period from developmental psychology, where this refers to a limited period in which some event or process must occur to facilitate progression.⁴⁰

10.3.6 Ongoing support from OEI or faculty

Several New Registrants reported receiving ongoing support from their former OEI (e.g. limited library access or hosting and moderating an online discussion forum), or from former tutors (sometimes delivering OEI support to alumni and sometimes individual arrangements between tutors and some of their former students). Other New Registrants had not sought help from their former OEI or tutors, but reported a belief that it would be available if they needed to ask. Ongoing OEI commitment to graduates is commendable and different levels or types of ongoing support may confer a market advantage when recruiting students. Individual support was highly valued by the New Registrants who reported receiving it. However, individual arrangements require careful professional judgements from faculty, since there may be conflicts with the tutor's contracted activity for the OEI and because individual arrangements make it more difficult to check equality of opportunity. The group of New Registrants for whom individual support from former tutors may be most appropriately targeted is those who are particularly vulnerable because they are lone practitioners.

10.4 Positioning in relation to other professions

Where osteopathy appears to situate itself as a discipline is a matter of interest, which has a bearing on preparation for practice. Most often, study participants described osteopathy as a manual therapy. However, medicine was the profession to which participants most often compared osteopathy. In terms of the practice of osteopathy these comparisons almost exclusively positioned osteopathy as different to traditional medicine. However, in terms of structures and processes to support preparedness to practise and transitions to practice, alignment with the medical profession was often regarded as desirable. For example, some faculty and students reported representatives from the GMC had been invited in to talk with students as part of learning and teaching about professionalism; mentorship frameworks for new GP's and the Foundation Programme for junior doctors¹⁵ were also cited as possible processes for supporting transitions in professional practice.

Positioning in relation to medicine may result from: a desire to align osteopathy with the most visible, powerful and autonomous healthcare profession to gain credibility and status; the ease of accessing information about the medical profession's structures and processes to support novice practitioners and other career transitions; or possibly, frequent interactions between osteopaths and GPs, resulting in familiarity. However medicine is a very large profession, located at the heart of the NHS: it can sustain a two-year structured foundation programme to support the transition from university to professional practice,

followed by specialist training programmes lasting between four and eight years. Furthermore, while experienced doctors provide mentorship and supervision for junior doctors, most other professions in multidisciplinary teams (but particularly nurses, pharmacists and midwives) also provide some supervision of junior doctors' work, despite the difficulties of negotiating steep power gradients to speak up.¹⁶¹⁻¹⁶³ This supports patient safety and helps doctors-in-training to develop both within their specialist roles and as members of interdependent multidisciplinary teams. In addition, private practice comes much later in medical careers. While some of the structures and processes which support medical practitioners' preparedness to practise and safe practise during extended years of training could offer useful insights for the osteopathic profession, there may be other professions with circumstances, structures and processes that are more aligned with the needs and resources of the osteopathic profession. For example, it has already been noted that study participants defined osteopathy as a manual therapy. This suggests scrutiny of the structures and processes used by physiotherapy and chiropractic. In relation to evidence-based practice (section 7.4), study participants reported that the physiotherapy literature was an important source of evidence for some aspects of their osteopathic practice. This underlines the potential affinity between osteopathy and physiotherapy, which may make comparisons of approaches to preparedness to practise fruitful.

The main areas in which osteopathy has greater challenges than physiotherapy in relation to preparedness to practise and support for novice practitioners, is the high incidence of self-employment and lone practitioners among recently qualified osteopaths. In this respect a comparison with chiropractic practice is likely to be more fruitful. Other professions that have a relatively high incidence of private practice from early in practitioners' careers, and well-developed structures and processes to support the transition into practice, include veterinary practice, dentistry, optometry and pharmacy. We suggest that it would be useful to examine structures and processes in these professions to identify those which, with suitable modifications, may support osteopaths' preparedness to practise and transitions into practice.

10.5 How trustworthy are the study findings likely to be?

The trustworthiness of the study findings relates partly to who contributed data and who did not; partly to rigorous data analysis processes and partly to the quality of interpretations drawn from the data analysis.

10.5.1 Participants and non-participants

The New Registrants' questionnaire yielded 127 responses (response rate 24.5%) this was lower than response rates for several healthcare professions (medians 50% to 62%) in published studies between 1996 and 2005 which were synthesised by Cook and

colleagues,¹⁹ who concluded that response rates from healthcare professionals were falling. Low response rates become a problem if there are systematic differences between responders and non-responders.⁹ In this study non-respondent analyses examined the degree to which questionnaire respondents might be considered typical in respect of demographic and work-related characteristics: see section 2.4.1 for methodology and sections 3.3 and 3.4 for findings. We found that respondents to the New Registrants' Survey could be considered representative of the complete population of GOsC New Registrants in respect of: gender, the OEIs at which they studied and the countries in which they were practising. However, a higher proportion of respondents were 35 or older, than in the wider population of GOsC New Registrants (section 3.3.6). In addition, when compared with NHS non-medical workforce data, although the expected number of New Registrant Survey respondents self-identified as White, significantly fewer respondents than expected identified themselves to be in a different ethnic group, while more than expected declined to identify their ethnicity (section 3.3.7). However, this finding needs to be contextualised by the fact that 89% of respondents to this study's New Registrants' questionnaire reported their ethnicity, whereas the GOsC Register contained this information for only 20% of New Registrants. Finally, we were unable to compare the employment profiles of survey respondents with non-respondents (section 3.3.4) because no comparison data exists. It is difficult to gauge any impact from the two significant differences found, but this study draws attention to these possible sources of bias: something which is often overlooked in published studies.^{19,20}

The response rate for the Colleagues and Employers' Survey was 15.7% (61 responses), which was disappointing. Non-respondent analyses showed that the Colleagues' and Employers' Survey respondents were representative of the wider population of experienced osteopaths in respect of the geographical region in which they practised. However, experienced osteopaths working alongside graduates of the British School of Osteopathy were over-represented. By definition, the Colleagues' and Employers' Survey focused on New Registrants who worked in group practices. It did not seek professional opinions about the preparedness of New Registrants who become 'single-handed' or 'lone' practitioners, although we received some comments about this group.

Focus group discussions with final year osteopathy students were held at six of the eight UK OEIs from which New Registrants graduated. We do not know how many students the OEI key contacts invited to participate in the focus groups or interviews, or the degree to which they were either purposively selected or a convenience sample. However the focus group moderators gained an impression of convenience sampling, based on inviting final year students who were in college on the day of the focus group.

Although we expressed a particular interest in interviewing clinic tutors and also OEI faculty with roles that engendered an overview of the curriculum and graduates' early careers, for example course directors, we do not know which or how many faculty OEI key contacts invited to contribute their views. Group interviews were dependent on the availability of

faculty on the same day as the research fellow's visit to conduct a student focus group. Data analysis did not separate the views of clinic and non-clinic tutors, since some group interviews were mixed.

At the request of the OEI, we have taken the unusual step of naming one OEI that, unintentionally, did not host focus group discussions for faculty and final year students. The London School of Osteopathy (LSO) intended to host focus groups and the research team intended to facilitate these groups. However, miscommunications led to vital dates being missed and, consequently, the focus groups could not be conducted within the study period. This prevented LSO faculty and students from having a voice within the focus group data. Nevertheless, eight LSO New Registrants (20%) contributed to the New Registrants' Survey (section 3.3.2): this was the median response rate for New Registrants from different OEIs (Table 2). In addition two colleagues or employers of LSO New Registrants (5%) contributed to the Colleagues' and Employers' Survey (section 3.4, see Table 11): a low but not uniquely low response rate.

10.5.2 Data collection procedures, analysis and interpretations

We tried to ensure that all stakeholders meeting the inclusion criteria for the study were contacted so that they had the opportunity to contribute to the study, if they wished. Careful interrogation of the GOSC register by a GOSC officer tried to identify all New Registrants, then experienced osteopaths with the same practice address (Colleagues and Employers). Where email contacts failed, letters were sent by post. Faculty and final year students were contacted via key contacts at OEIs. Notices in *The Osteopath* also drew attention to the study. PMCl collected all interview and focus group data; DC observed a sample of focus groups to provide researcher triangulation.

Data analysis was conducted mindfully, taking account of good practices for analysis of quantitative and qualitative data, and then for the synthesis of quantitative and qualitative research.¹⁶⁴⁻¹⁶⁵ To help ensure a high quality product, the research team divided the work of conducting and checking analyses. DF led the quantitative analysis, which was reviewed by PMCl and DC. PMCl compiled the initial qualitative analysis. DC independently coded a sample of interview and focus group transcripts. All authors compared and cross-checked the independently generated sets of codes and discussed discrepancies. DF and PMCl then conducted further qualitative analyses, which were checked by DC. Final analyses were cross-checked with raw data before interpretation in relation to the wider literature. Throughout the study, reading the wider literature also prompted the researchers to interrogate the data in certain ways to check concordance with others' findings and theories. Extensive cross-referencing within the final report allows readers to locate the evidence for arguments made throughout the report, but particularly in the later chapters. The use of a large number of quotations from the qualitative data also allows readers to make judgements about the trustworthiness of the account provided in the report.

We believe the study was rigorously conducted and interpretations are well-evidenced.

10.6 Limitations of the study

10.6.1 Exclusion of graduates who did not register with the GOsC

Osteopathy graduates who did not seek to become practising osteopaths and therefore, did not register with the GOsC, were excluded from the study: they may well have had different perspectives on the topic of preparedness for practice. Some UK osteopathy graduates may have sought registration outside the UK and would not have been identified in our New Registrants population. We do not know the total number of UK osteopathy graduates in 2009 and 2010, so we cannot establish the proportion of the total which this study's population of 518 New Registrants represents.

10.6.2 Unknown regional distribution of New Registrants' survey respondents

A question asking the region in which new registrants practised was accidentally omitted from the online survey, preventing regional analysis of responses. This omission may be important because the GOsC register shows that new registrants are heavily concentrated in London and the South East (55%), where there is also a concentration of CPD opportunities and potential mentors. This may have influenced responses to some questions. New registrants were sparsely distributed (3%-4% of the 2009 and 2010 cohorts) in each of the following regions (in descending order): North West England, Scotland, outside Europe, North East England, Europe excluding the UK; while very few recent osteopathy graduates (<1%) worked in Northern Ireland, Wales and the Isle of Man.

10.6.3 Experienced osteopaths' perspectives on New Registrants' preparedness to practise skewed towards experience of those working in group practices

The opinions of colleagues and employers of newly qualified osteopaths were solicited and considered in detail in Part II (Chapters 3-8), but their opinions were focused on those new registrants who work in group practices. In this study that was just over half (55%) of the New Registrant survey respondents. This study had no means to obtain professional opinions on the preparedness to practise of newly qualified osteopaths working single-handed. We do not know whether this group differs systematically from New Registrants who work in group practices. It should be noted that some New Registrants in group practices are engaged to cover days when their colleagues are not present, effectively rendering them single-handed practitioners. In medicine, single-handed GPs are controversial and becoming less common. They provide good care, and continuity, which patients value; but if quality problems develop it may take longer for this to be drawn to the attention of service commissioners, quality monitoring and professional bodies, during

which time problems can become more serious.¹⁶⁶⁻¹⁶⁹ Single-handed practitioners may find it more difficult to protect time for CPD and to ensure their own wellbeing.

10.6.4 Restricted definition of Colleagues and Employers

Interrogation of the GOsC database identified 389 experienced osteopaths (registered before 2008) working at the same practice address as one or more of the New Registrants. This became the 'Colleagues and Employers' population for this study and ensured an osteopathic focus, based on the experiences and wisdom of practitioners with a minimum of three years practice experience. It therefore excluded perspectives of: less experienced osteopaths working alongside New Registrants and experienced osteopaths who had worked alongside New Registrants but were not currently working at the same practice address as a 2009 or 2010 graduate. However, a second online questionnaire was available to capture the views of any osteopath who wished to contribute to the study but had not been captured in the Colleagues and Employers population (section 2.2.4). Perhaps more significantly, the perspectives of non-osteopathic colleagues and employers lay beyond the scope of this study. Interprofessional perspectives of osteopathic practice and New Registrants' preparedness to practise could be very helpful to the profession and could be addressed by new research.

10.7 Summary

For a variety of reasons, preparedness to practise can never be fully complete at the end of an osteopathy degree (or any profession's pre-qualification education). This is predominantly because practice is highly variable and constantly evolving and certain aspects of professional learning have to occur through engagement in workplace practices. This was not fully recognised by the osteopaths in this study, although we discovered a strong discourse of 'safe, if not always effective'. This represents recognition that new graduates have passed a certain threshold (safety) and can now begin unsupervised practice, but still have much to learn. Study participants reported a surprising variety of strengths and weakness among New Registrants, although gaps in business and entrepreneurial skills and patient management skills were very commonly reported. The emphasis on safety within osteopathic education resulted in lower priority being accorded to interpersonal and communication skills, which are also difficult to assess, and preparation for business. This chapter included a wide range of examples of ways in which other professions have approached the development and assessment of interpersonal and communication skills. We also examined ways in which the development of interpersonal and business expertise might be better integrated within elements of the curriculum that primarily address clinical skills.

There was marked diversity, variability and uncertainty at all stages of osteopaths' development from students to competent practitioners. This presented problems for new graduates entering osteopathic practice, but also formed part of the profession's identity which prized diversity and autonomy. Up to a point, autonomy is empowering, but it can tip over into isolation. Many New Registrants struggled with feelings of isolation during their transitions to professional practice. We examined several structures and processes that may support New Registrants' transitions to practice, including: attention to the role of clinic-based and placement-based learning; mentorship during the early months of qualified practice; conditional registration or a supported foundation period; early engagement with CPD; working in group practices and multidisciplinary environments, and formal or informal ongoing support from OEIs and faculty. Numerous examples of the approaches and insights from other professions were provided.

Chapter 11 Summary of osteopathy graduates' preparedness to practise

11.1 Introduction

Having provided considerable detail about facets of osteopathy graduates' transitions to practice in Chapters 4-9, and discussion in relation to other professions and the wider literatures about learning and workplaces in Chapter 10, we wish to provide a very succinct summary here. A simple traffic light system will be used to summarise levels of preparedness for different facets of practice: green for a consensus of sound preparedness; amber for facets of preparedness where this study found ambivalence, mixed messages, considerable diversity or a consensus of moderate levels of preparedness; finally red for facets of preparedness where there was a consensus of poor preparedness. This is necessarily an over-simplification of osteopathy graduates' preparedness to practise and should not be taken out of the context of chapters 4-10.

11.2 Green

Osteopathy graduates' up to date clinical and scientific knowledge was recognised and commended by experienced osteopaths. Adequate underpinning knowledge is a prerequisite for correct clinical reasoning and action, so this is a vital aspect of preparedness to practise.

Osteopathy graduates were considered safe to commence autonomous osteopathic practice.

Graduates were considered to be competent in a limited range of clinical processes and techniques, which could collectively form the basis of initial clinical practice.

Graduates were conversant with Standards for Practice.

Graduates understood and broadly supported evidence-based practice, and could play an active part in continuing debates about the contested nature of evidence in the context of osteopathic practice.

11.3 Amber

Colleagues and Employers felt that New Registrants often exhibited insufficiently incisive clinical reasoning and excessive caution, linked to over-investigation or over-treatment, but

they varied in the extent to which they viewed this as indicative of lack of preparedness to practise or an expected and transient part of beginning practice.

Osteopathy graduates interpersonal and communication skills were regarded as less well developed than their clinical knowledge and clinical skills, particularly in relation to communication with other healthcare professionals (as opposed to direct colleagues). Writing letters to GPs was better-developed than other aspects of interprofessional collaboration. Experienced osteopaths doubted osteopathy graduates' preparedness for responding well in challenging situations.

Linked to the previous two areas of limited preparedness, osteopathy graduates were considered to be only partially prepared for developing effective, patient centred treatment plans and promoting self-help.

11.4 Red

The data from this study suggested that osteopathy degrees placed such emphasis on safe clinical practice that it displaced attention from other aspects of professional practice. Whilst safety is of paramount importance, it is also important that adequate attention is paid to developing interpersonal skills that are essential for osteopathic practice.

There was widespread concern that osteopathy graduates did not properly appreciate the skills and effort required to build and maintain a successful osteopathy practice. In particular, they lacked appreciation of how small businesses build by word of mouth and the factors that affect this.

Chapter 12 Recommendations

Recommendations for different constituencies have been grouped as follows:

Recommendations for the GOsC (section 12.1), Recommendations for practising osteopaths (section 12.2), Recommendations for OEIs (section 12.3) and Recommendations for future research (section 12.4).

12.1 Recommendations for the GOsC

12.1.1 CPD requirements during first year of registration

There was a perception that the current waiver of CPD requirements during, roughly, the first year of registration, could act as a perverse incentive in the sense of not 'counting' and thereby discouraging first year CPD. It is recommended that the intent and wording of this aspect of the CPD requirements are revisited. Further, we commend the suggestion reported in section 7.5.1, that the initial CPD requirement be redefined as an extended period for compliance, rather than an initial waiver.

12.1.2 Supporting access to journals and other resources to support CPD

We recommend that, in conjunction with OEIs and practising osteopaths, the GOsC examines the current GOsC-funded access to a range of research journals via **o zone** to review whether the selection of bibliographic material is considered to be appropriate. Participants in this study stressed that (as at present) the selection should extend beyond osteopathy journals. The current trend towards OEIs making some of their library resources accessible to alumni should be encouraged: this study's participants considered bibliographic databases, books and other resources to support practice development and evidence based or evidence informed practice to be important, in addition to journals. Access to such resources needs to be affordable for osteopaths at different stages of their careers, but particularly for recent graduates. It may be important for the GOsC to enable equal access to a shared core of resources, rather than accept inequality linked to diverse arrangements with registrants' former OEIs.

12.1.3 Reviewing the practices of other healthcare and wellbeing professions or occupational groups in relation to supporting novice practitioners' transitions into practice.

Most of the healthcare professions that are embedded in the NHS do not permit newly registered practitioners to commence practice without some type of supervision, at least in the very early months. However, health and wellbeing professions that are predominantly located in the private sector, as is the case for osteopathy, vary in the degree to which they

require or encourage supervision, mentorship or a structured period of supported and monitored initial practice. It is recommended that there would be value in investigating the practices of other health and wellbeing professions in relation to novice practitioners to establish whether any provide models that could strengthen the support received by novice osteopaths at a sustainable cost and in a manner that would garner support from the wider profession. This study found little support for a period of conditional registration but widespread support for the development of more extensive and less variable mentorship practices. The GOsC may have a role in promoting good quality mentorship for all New Registrants.

12.1.4 Considering the particular needs and vulnerabilities of New Registrants working as lone practitioners.

Whilst it cannot be assumed that New Registrants in group practices receive reasonable support and oversight during their transitions to practice, New Registrants working as lone practitioners are undoubtedly more vulnerable and may need assistance to garner the support they require. The GOsC may have a role in providing advice which is specifically targeted for this group and might also seek to encourage regional osteopathic networks to pay particular attention to the needs of New Registrants working as lone practitioners.

12.2 Recommendations for practising osteopaths

Many practising osteopaths already think and act in these terms, but it is recommended that all practising osteopaths regard high quality support for the development of student and novice osteopaths as a duty of the wider profession. There are many different ways to contribute to this and some osteopaths will be able to contribute more than others.

We recommend that it would be expedient for all osteopaths to recognise New Registrants' transitions to practice (and indeed any practitioner's move from one work environment to another) as Critically Intensive Learning Periods (CILPs)⁶⁰ (see sections 10.2.2 and 10.2.5), during which performance will be impaired by the need to acquire context-specific knowledge and understanding. More proactive support during CILPs and the eradication of workplace practices that impede everyone's performance, should promote better transitions and an overall improvement in performance: even small changes can make a worthwhile difference.

12.3 Recommendations for OEIs

12.3.1 Reviewing clinic and placement learning

It is recommended that OEIs review Clinic and placement learning to build upon existing good practices and mitigate areas that may require attention. Some areas that may benefit from review are listed below. Each OEI that contributed to this study has a variable profile against the list below: strengths and weaknesses. This variation suggests that every OEI could spotlight and share one or more areas of good practice, which others could consider in relation to their own context in order to encourage discipline-wide improvements. However, good practices are context-specific so none will transfer effectively without tailoring for local circumstances. It is recommended that each OEI begins by selecting the most pertinent issues from the list below for, on the one hand, dissemination of good practices and, on the other hand, targeted attention to developing current practices.

- The variety and sequence of clinic and placement learning environments through which students rotate.
- The ways in which the development of incrementally improving clinical reasoning is supported.
- The ways in which consolidation is supported for key clinical techniques and procedures.
- The scope for providing longitudinal practice experiences, which allow students to evaluate the consequences of earlier clinical decisions, reassess and update plans.
- Faculty development for clinic tutors.
- Rehearsal of triage and, where appropriate, referral to others (for effectiveness as well as safety).
- Attention to the development and (at minimum good quality formative) assessment of interpersonal and communication skills.
- The ways in which simulation (defined broadly to include role play, physical simulators and evolving case studies) augments or could complement clinic and placement learning. And identification of learning objectives for which simulation may be a better learning environment than clinic.
- Whether borderline passing students might be given an option to participate in additional clinical support provided to borderline failing students.

12.3.2 Examining the rhetoric of 'safe, if not always effective'

While the rhetoric of 'safe, if not always effective' is a useful, realistic summary of the expected level of competence for a recent graduate, and should guard against complacency in the early months of registration, it could also have the potential to limit ambition and learning during osteopathy degrees. We recommend that OEIs critically examine the discourse of 'safe, if not always effective to' consider:

- In what ways, if any, this discourse has a useful function that could be strengthened. For example, directing attention to the need to be effective, whilst still safe, and the ways in which this might be achieved.
- In what ways, if any, this discourse limits faculty and students' aspirations and, consequently, achievements.

12.3.3 Supporting access to journals and other resources to support CPD

Whilst realising that licensing arrangements are complex and can be prohibitively expensive, we recommend that in conjunction with the GOsC, OEIs individually and collectively examine current provision and future possibilities for the provision to alumni of affordable online access to bibliographic databases, relevant journals and other resources to support practice development and evidence-based practice.

12.3.4 To examine the rationale and contexts provided for reflective practice

Reflective practice is essential for career-long professional development. It appeared that all OEIs had embedded elements of reflective practice within their programmes, but the extent varied and students' appreciation of these curriculum elements varied. Some faculty were not confident about the reflective elements in their curriculum. During this study it was not always clear whether students were helped to understand why the effortful process of reflection is necessary and, when coupled with heeding feedback and a conscious intention to improve, would improve expertise. We recommend that OEIs review how reflection is introduced to students and whether the rationale for its use is clear to faculty and students at each relevant point in the curriculum. Focused reflection may be more effective (and more achievable) than unfocused reflection. Students are likely to benefit from a systematic plan to direct their attention towards reflection on key features of professional practice as the natural progression of the curriculum and exposure to a variety of learning contexts allows. A map of contexts and foci for reflection across the curriculum would help ensure that attention to different aspects of professional practice is proportionate and that important aspects are not inadvertently overlooked. However reflection alone is not sufficient and students should be helped to develop the habit of seeking and valuing third party feedback, for example from colleagues and patients.

12.3.5 Strengthening support for the development of high quality interpersonal and communication skills

OEIs are currently working to strengthen this aspect of osteopathy programmes and there were some examples of successful developments. It is recommended that:

- Current curriculum and faculty development work continues, particularly in relation to clinic education.

- Links between the quality of osteopaths' interpersonal skills and patients' outcomes are more strongly made; similarly the links with building a successful practice.
- The scope for increased attention to formative (and eventually summative) assessment of interpersonal skills is considered.
- The potential of well-chosen and well-facilitated simulations is considered.
- Efforts are made to establish a habit of seeking and valuing feedback from patients and colleagues, to complement the development of self-assessment through reflective practice.

12.3.6 Strengthening preparation for entrepreneurial and business aspects of osteopathic practice

Whilst it will never be possible to fully prepare osteopathy students for the realities of developing and maintaining an osteopathic business, we recommend that preparation is strengthened in the following ways:

- Attention to the ways in which osteopathy students' expectations of building or maintaining a business are shaped by the formal and informal curriculum, with a view to engendering reasonably realistic expectations.
- Adding value to clinic and placement learning by, for example,
 - Highlighting the relationships between interpersonal skills, the quality of the patient experience and business development.
 - Involving students in the marketing and day to day management of in-house clinics.
 - Considering the scope to encourage business-focused placements in addition to clinically-focused placements.
- Making a distinction between relatively enduring principles and rapidly changing aspects, such as market conditions, regulation and technologies; providing some education about principles, but mainly investigation and appraisal expertise for rapidly changing areas (possibly best approached through case studies or problem-based learning).
- Raising awareness of both osteopathic and non-osteopathic sources of business-related advice and networking opportunities: particularly free and low-cost sources. Opportunities for networking with recent graduates may be helpful in this respect.

12.3.7 Preparing tomorrow's mentors

OEs (and the osteopathic profession more widely) may wish to debate the value of introducing a limited amount of preparation for educator and mentor roles within osteopathy degrees: this could develop knowledge and skills which would support the next generation of osteopaths, but also help develop a culture of mentorship and educational facilitation as integral to professional practice.

12.3.8 Preparedness for alternative career paths

It cannot be assumed that the sole purpose of an osteopathy degree is entry to the osteopathic profession. Career destinations for graduates who will not commence osteopathic practice or who will leave relatively quickly should also be considered. It is recommended that information and advice about additional career destinations is available.

12.4 Recommendations for future research

12.4.1 Lone practitioners

Insufficient is known about newly qualified osteopaths who only work as lone practitioners, yet their preparedness to practise may need to be at a higher level than others to ensure patient safety and enhance the likelihood of business success, whilst safeguarding the reputation of the profession. Future research should examine the population and practice of single-handed osteopaths to establish whether there are advantages and disadvantages to single-handed practice, and whether any targeted support is advisable.

12.4.2 Interprofessional perspectives

Interprofessional collaboration with GPs, and a range of other professionals, is a central characteristic of osteopathic practice, but the perspectives of non-osteopathic colleagues lay beyond the scope of this study. Interprofessional perspectives of osteopathic practice and New Registrants' preparedness to practise could be very helpful for the development osteopathic practice and education. This could be addressed by new research.

12.4.3 Those who leave the profession

To fully understand preparedness to practise, it would be necessary to elicit the perspectives of osteopathy graduates who do not become osteopaths, or who leave the profession very quickly. The former lay outside the scope of this study and the latter cannot be identified from the 'snapshot' interrogation of the GOsC Register which identified the New Registrant population for this study: a longitudinal approach would have been necessary to identify those joining then leaving the Register. Firstly, new research should examine the experiences of osteopathy graduates who do not register with the GOsC or an equivalent body overseas within, say, two years of graduation. Collaboration between OEIs and the GOsC would be necessary to identify this group. Secondly, longitudinal monitoring of the GOsC Register could easily identify recent graduates who join the Register, but do not sustain their registration after one or two years: the period during which preparedness to practise will make its impact (along with other factors). New research could then investigate the experiences of osteopathy graduates who begin, but do not sustain, osteopathic careers.

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Many thanks to all study participants: New Registrants, their Colleagues and Employers, Final Year Students, OEI Faculty and participants in the Stakeholder Panel.

Authors' contributions

Jointly, all authors designed the study and the data collection instruments, and discussed the themes and interpretations presented within this report. PMCl conducted all focus group and individual interviews and coded all the resultant data; to enable triangulation of researcher perspectives DC participated in a proportion of focus group interviews and independently coded a proportion of transcripts. DF analysed the survey data, which was also reviewed by PMCl and DC. All authors have reviewed the whole report. DF is the guarantor for the study.

Appendix 1a New Registrants' Questionnaire

The physical appearance of the online survey cannot be reproduced here due to its multi-screen format and, for example, the use of 'radar buttons' and drop-down menus.

However, the tables below show the section headings, individual questions, the style of response requested and the options provided for closed questions.

Section 1. Demographic questions
1. Year of registration In which year did you first register with the General Osteopathic Council?
2009; 2010; other (please specify)
2. In which year did you complete your osteopathic education programme? Was it: 2008: 2009: 2010; other (please specify)
2. Knowledge and skills
3. Knowledge. Describe up to 3 areas of clinical knowledge you feel you had greatest confidence in with regard to your understanding and ability to apply to practice.
Expanding text box
4. Describe up to 3 areas of clinical knowledge you felt least confident about with regard to your understanding and ability to apply to practice
Expanding text box
5. Clinical Skills Describe up to 3 areas of clinical skill for which you had greatest confidence in your understanding and ability with regard to practice
Expanding text box
6. Clinical Skills Describe up to 3 areas of clinical skill for which you had least confidence in your understanding and ability with regard to practice
Expanding text box
7. Please rate your level of agreement with the following statements:
7.a. I understand the concepts of evidence based practice
7.b. There is an adequate evidence-base for osteopathy practice
7.c. I can access up to date evidence to underpin my osteopathy practice
7.d. I am familiar with relevant clinical guidelines to underpin my osteopathy practice
7.e. I make use of contemporary research evidence to inform my osteopathy practice
7.f. Evidence-based practice is an unrealistic ideal
Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

8. Have you undertaken any Continuing Professional Development or received other support that was focused on professional osteopathic practice (for instance skills development or ethics and osteopathic values) since graduating?

Yes/No

8.a. Please use the space below to elaborate or comment on this

Expanding text box

Section 3. Knowledge and preparation

9. Please rate your level of agreement with the following statements

9.a. My degree provided me with the knowledge needed for osteopathic practice.

9.b. My degree provided exposure to a variety of client groups (e.g. babies, older people, ethnic diversity, disability)

9.c. My degree provided exposure to diverse clinical conditions.

9.d. My degree provided sufficient supervised clinical practice.

9.e. The assessments undertaken during my degree prepared me as well as possible for osteopathic practice.

9.f. My degree taught me to evaluate my own competence.

9.g. My degree taught me how to update my skills and knowledge.

Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

Section 4. Clinical skills, knowledge and support

10. Since qualification, what if any Continuing Professional Development have you completed that focused on clinical skills and knowledge?

Expanding text box

11. What kinds of Continuing Professional Development would you have liked to access during your first year of registration?

Expanding text box

12. What factors do you take into account when undertaking Continuing Professional Development?

Expanding text box

13. Since qualification have you received mentorship or less formal support from a more experienced osteopath?

Yes/No

13.a. If you answered yes, please give an example of this

Expanding text box

14. Have you sought mentorship or other less formal support and found it unavailable?

Yes/No

15. If you have any further comments to make regarding mentorship and support arrangements for recent registrants please feel free to supply these in the text box below

Expanding text box

Section 5. Ways in which you have used your skills

16. How do you feel your Interpersonal and Communications Skills learning during your degree has prepared you for the following:

16.a Managing conflict (e.g. difficult clients, unrealistic expectations).

16.b Teamwork

16.c Making appropriate referrals or relaying advice on future treatment

16.d Consulting other professionals

Scale for each item: Not very well; Well; Very well; Excellently; Not sure

17. Without breaching confidentiality of clients or colleagues, name or describe up to 3 situations within osteopathic practice (with clients or colleagues) in which you felt your Interpersonal and Communication skills served you well

Expanding text box

18. Without breaching confidentiality of clients or colleagues, describe up to 3 situations within osteopathic practice (with clients or colleagues) where you felt you needed better Interpersonal and Communication Skills

Expanding text box

19. Have you undertaken any Continuing Professional Development or received other support for the development of your interpersonal skills?

Yes/No

19.a. Space for you to elaborate or comment

Expanding text box

Section 6. Standards for practice and recognising your limitations

20. To what extent are you able to use the GOsC standards for practice?

20.a. I am at least partly or more familiar with the most up-to-date GOsC standards for practice

20.b. The standards for practice were embedded in my osteopathy degree

20.c. Knowing the standards has enhanced my practice

20.d. It is easy to apply the standards in my practice

20.e. I use the standards for practice as a baseline for professional practice

20.f. I feel confident in my abilities to recognise my strengths and areas for development in

my practice
20.g. I feel my training has enabled me to recognise the limitations of my practice and to practise safely
Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

Section 7. Being a business person and a clinician
21. Name up to 3 things that you feel you have done well to enhance your business as an osteopath
Expanding text box

22. Name up to 3 things that you would have liked to have learned about the world of business when you became a registered practitioner
Expanding text box

23. What kinds of Continuing Professional Development support are available for you to develop your business skills? Please give up to 3 examples if you are able.
Expanding text box
23.a. Please also tell us about any other business training courses you have attended outside of the osteopathy sector that you have found useful.
Expanding text box

24. If you were to describe the single most challenging aspect of the transition from student to autonomous practitioner/business person, what would that be?
Expanding text box

Section 8. Any other comments
25. Please feel free to write about your experiences in the box below if you have anything further to add or qualify on any aspect of the areas covered by the survey

Section 9: Role related data
26. At which Osteopathic Education Institution did you study?
Drop-down menu
26.a. If 'other' please specify in the box below

27. Employment: Are you currently practising in:
The UK; Another European country; Outside of Europe

28. Employment: Are you
Self employed in a group practice; An associate practitioner employed in a group practice; Sole trader; Not currently practising

29. What is your gender?

Male/female

30. Age: What is your age range?

20-34; 35-49; 50-65; over 65; Rather not say

31. What is you' ethnic background?

Drop-down menu

32. Do you have any other professional health care qualifications? Please answer in the box below if applicable, and the professional body registered with.

Expanding text box

Appendix 1b Employers' and Colleagues questionnaire

The physical appearance of the online survey cannot be reproduced here due to its multi-screen format and, for example, the use of 'radar buttons' and drop-down menus.

However, the tables below show the section headings, individual questions, the style of response requested and the options provided for closed questions.

Section1. About you
1. How many years have you worked as a qualified osteopath?
under 5; 6-10; 11-15; 16-20; 21-25; 26-30; more than 30 years
2. Employment: Are you
An employer/lead practitioner in a group practice; Self employed in a group practice; An associate practitioner/colleague in a group practice
3. How many osteopaths work within your practice?
4. In which region to you currently work as an osteopath?
Drop-down menu
Section 2. About your new registrant(s)
5. In which year did your new registrant first register? We are particularly interested in those who first registered in 2009 and 2010.
2009; 2010; Other; Don't know
5.a. If your answer was 'other year' please tell us which year this was
Expanding text box
6. From which Osteopathic Education Institution did your new registrant graduate?
Drop-down menu
6.a. If you have more than one new registrant at your practice, please specify how many and from which Osteopathic Institutions they graduated
7. Age: What is their age range?
20-34; 35-49; 50-65

Section 3. Understanding of Osteopathic Practice, Osteopathic Values, and Standards for Practice

8.a. New registrants show strong evidence of osteopathic values.

8.b. New registrants are familiar with the GOSc standards for practice.

8.c. New registrants are transferring the GOSc standards into their everyday clinical practice.

8.d. New registrants apply their osteopathic values and standards well in clinical practice

Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

Section 4. Clinical Ability

9. How well do you feel new registrants are prepared overall for clinical practice?

Very well; Sufficiently prepared; Not well enough

10. What are the main clinical strengths evidenced by new registrants?

Expanding text box

11. What are their main areas for clinical development?

Expanding text box

12. In your experience, what are the areas of practice that new registrants are best at?

Expanding text box

Section 5. Strengths and areas for development

13. In your experience, what are the areas of practice that new registrants are least good at?

Expanding text box

14. What mechanisms do you feel could be put in place to support new registrants in their first year of practice?

Expanding text box

15. What mechanisms would you like to see put in place to rectify any shortcomings that new registrants might have in the first year of their practice?

Expanding text box

Section 6. Support and Networks

16. To what extent do the registrants you were thinking about in question 5 (those that are now your colleagues) have access to supervision, mentorship or continuing professional development?

Expanding text box

17. What supervision, mentorship, or continuing professional development are you aware of that is available to new registrants in: A) Your local area B) Your region

Expanding text box

18. Do you provide supervision or mentorship for any of the new registrants you were thinking of in question 5?

Yes; No

19. Do you offer supervision or mentorship to new registrants other than those you were thinking of in question 5?

Yes; No

Section 7. Using interpersonal skills effectively

20. What do you feel are new registrants' best communication skills?

When working with patients; When working with colleagues; When liaising with other professionals; other (please specify)

21. In which area are their communication and interpersonal skills less well developed?

When working with patients; When working with colleagues; When liaising with other professionals; other (please specify)

22. How effective are new registrants in the interpersonal aspects of patient management?

22.a. New registrants are able to explain treatments effectively to patients in ways which are accessible and understandable?

22.b. New registrants are able to respond appropriately to patient's anxieties, frustrations and pain using effective verbal and non-verbal skills

22.c. New registrants are able to use interpersonal skills *effectively* in the management of challenging situations (such as unrealistic patient expectations, adverse events, vulnerable patients, etc)

Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

Section 8. Business acumen

23. Please answer the following statements as objectively as you can

23.a. New registrants I have worked with are good at customer care. -- Please respond by checking one answer per statement

23.b. New registrants I have worked with are good at managing budgets. -- Please respond by checking one answer per statement

23.c. New registrants I have worked with are good at strategic and ongoing developments -- Please respond by checking one answer per statement

23.d. New registrants I have worked with have good marketplace awareness. – Please respond by checking one answer per statement

Likert Scale provided for each item: Strongly disagree; Disagree; Slightly disagree; Slightly agree; Agree; Strongly agree

24. To what extent do new registrants understand the interface between clinical practice, customer care and business growth

very well; well; adequately; not well

25. What core business responsibilities if any do you assign new registrants?

Expanding text box

26. What area of business/entrepreneurship are new registrants strongest in?

Expanding text box

27. What area of business/entrepreneurship are new registrants least good at?

Expanding text box

Section 9

28. Please use the text box below to add any further observations you have on the preparedness to practise for new registrants that have not been addressed in the survey questions

Expanding text box

Appendix 2: Additional tables

New Registrants' Questionnaire

Anonymous summary data from the GOsC Register revealed the regional distribution of all New Registrants (Table 27).

Region	GOsC Register (%)
South East	146 (28.2)
Greater London & Middlesex	140 (27.0)
Eastern & Home Counties	55 (10.6)
Central England	49 (9.5)
South West	41 (7.9)
Northern England - West	22 (4.2)
Outside EU	15 (2.9)
Scotland	15 (2.9)
Europe: outside UK	14 (2.7)
Northern England - East	14 (2.7)
Northern Ireland	3 (<0.1)
Wales	3 (<0.1)
Isle of Man	1 (<0.1)
Total	518

Table 27: Regional distribution of New Registrants

Data extraction to identify experienced 'Colleagues and Employers' of New Registrants (see section 2.2.2), found that only 163 New Registrants (31%, see Table 28) shared their practice address with experienced osteopaths.

	GOsC New Registrants (%)
0 or no practice listed	350 (67.6)
1	55 (10.6)
2	39 (7.5)
3	17 (3.3)
4	15 (2.9)
5	19 (3.7)
6 or more ^a	18 (3.6)
missing	5 (<0.1)
Total	518

^a range 6-21

Table 28: Number of experienced osteopaths (Colleagues and Employers) registered at the same practice address as the New Registrant

The observed and expected numbers of respondents self-identifying as White were almost identical (Table 29), but significantly more than the expected number of respondents declined to identify their ethnicity (chi-squared test of proportions, $\chi^2=15.9$, 2df, $p<0.001$).

	Observed N	Expected N	Residual
White	97	98.0	-1.0
All other ethnicities	9	16.0	-7.0
Declined to answer	13	5.0	8.0
Total	119		

Table 29: Comparison of observed and expected frequencies of respondents identifying their ethnic group

Colleagues' and Employers' Survey

There are very few practising osteopaths in some geographical regions, so regions had to be combined to permit a non-respondent analysis of the regional distribution of respondents to the Colleagues' and Employers' Survey (Table 30). This showed that there was no significant different difference between the regional distribution of survey respondents and the regional distribution of all those invited to complete the questionnaire (chi-squared test of proportions, $\chi^2=4.951$, 5df, $p=0.422$).

Region	GOSc Register	Respondents	Expected respondents	Residual
South, South East & East	149	17	23.4	-6.4
London	86	12	13.5	-1.5
Northern England & Scotland	69	13	10.8	2.2
Central England	45	10	7.1	2.9
South West & Wales	33	7	5.2	1.8
Overseas	7	2	1.1	.9
Total	389	61		

Table 30: Grouped data for non-respondent analysis of regional distribution

Graduates from the British School of Osteopathy were over-represented in the New Registrants with whom Colleagues' and Employers' Survey respondents worked (Table 31; chi-squared test of proportions, $\chi^2=17.457$, 6 df, $p=0.008$).

	GOsC (%)	Frequency	Expected frequency	Residual
British School of Osteopathy	176 (34.0)	37 (55.2)	22.1	14.9
European School of Osteopathy	79 (15.3)	10 (14.9)	10.0	0.0
British College of Osteopathic Medicine	76 (14.7)	6 (9.0)	9.6	-3.6
College of Osteopaths	44 (8.5)	4 (6.0)	5.5	-1.5
Oxford Brookes University	55 (10.6)	3 (4.5)	6.9	-3.9
London School of Osteopathy	40 (7.7)	2 (3.0)	5.0	-3.0
Surrey Institute of Osteopathic Medicine	39 (7.5)	2 (3.0)	4.9	-2.9
London College of Osteopathic Medicine ^a	2 (<0.1)	1 (1.5)		
Missing ^a	0	2 (3.0)		
Total (exceeds 61 due to some respondents working alongside multiple New Registrants)	518	67		

^a excluded from analysis due to low expected frequencies

Table 31: Comparing New Registrants' OEs as reported by Colleagues and employers, with the distribution for all GOsC New Registrants

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All web links were checked on 5 March, 2012

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