

Osteopathic Practice Framework Final Report 25th January 2010



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Osteopathic Practice Framework

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Executive Summary

The Osteopathic Practice Framework document outlined the General Osteopathic Council's (GOsC's) perception of a lack of clarity about what constitutes osteopathic practice and the challenges which this raises for GOsC as a regulator and the confusion it may provoke amongst the public. The consultation document presented a broad framework intended to describe the general principles which inform the osteopathic perspective on healthcare, indicate the potential types of clinical practice that may be encountered, and classified osteopathic approaches into those more commonly used and those less so.

This report derives from an in-depth analysis of the 306 consultation questionnaires received and transcripts of the debates at the regional consultation events.

Questionnaire data

The percentages cited below should be treated with great caution as some respondents indicated a supportive and/or positive response by ticking the 'yes' box(es) but then gave a very critical or negative response in their free text response, others indicated in their free text that they had ticked yes or no to the question they thought they should have been asked rather than the one actually asked and so on.

62% of respondents agree that there is a need to define the scope of osteopathic practice.

Benefits

The benefits associated with defining the scope of osteopathic practice include:

- bringing a greater understanding to the public, potential patients, and other healthcare professionals about what osteopathic practices and osteopathy have to offer;
- identifying what is special and unique about osteopathy;
- offering greater safety for osteopaths and patients and that this would increase osteopathy's acceptability to the NHS;
- helping osteopaths and the profession promote what they do better;
- encouraging cohesion within the profession; and
- supporting regulation.

Disadvantages

The disadvantages associated with defining the scope of osteopathic practice are that it would:

- inevitably be too narrow and limit the scope of practice;
- the activity of definition is reductionist and thus counter to the underpinning philosophy of osteopathy and therefore impossible;
- be restrictive and will not allow the profession to grow and develop;

- change the case mix that osteopaths treat;
- result in inappropriate misconduct and legal challenges; and
- divide the profession.

65% of the respondents agreed that the overall approach proposed to setting out a scope of practice seemed to be sensible.

Alternative approaches suggested were:

- starting with principles rather than treatments
- adopting an inclusive approach that embraces all parts of the profession
- asking osteopaths what they do
- looking at what is happening internationally
- making the document more succinct
- taking a different approach to consultation

The categorisation proposed was unpopular and contentious with fewer than half of the respondents (48%) agreeing with it. The main concerns and comments were that:

- one osteopath's "least typical" could be another's "typically encountered";
- the categories implied a hierarchy of worth or value;
- categorising in this way will become a self-fulfilling prophecy;
- how the GOsC developed and decided the categories;
- inclusion of 'fringe' techniques might have negative consequences for the profession over all; and
- why there was no description of what osteopathy is not.

Only 49% agreed that the types of practice included in each category accurately reflect current practice. Additional areas/techniques suggested for inclusion were:

- Buteyko (breathing technique)
- Facial release
- Neuro linguistic programming
- Manual techniques with the intention of indirectly treating the somatosensory cortex (homunculus)
- Prolotherapy
- Harmonic technique.

Some respondents suggested that it would be better to have a list of what is not included.

Additional concerns included:

- that establishing a framework might stifle research into 'less typically encountered' techniques;
- cost; and

- whether or not defining the scope of practice was really the business of the regulator.

Regional events

Discussion of the proposals at the regional events took the form a debate with comments and questions from the floor. The debates encouraged a polarisation of views and the comments made by the audience were influenced by the points raised by the presenters and commentary by the Chair. The following themes were distilled from the transcripts:

- the need to remain true to the origins of the profession;
- defining a scope of practice would necessarily be limiting both of the profession and individual osteopaths and would be likely also to stifle innovation;
- the need for an evidence base;
- the similarities and differences between osteopathy and other professions, in particular physiotherapists and chiropractors, and the importance or not of this;
- meeting the expectations of the public and other professions and the value to the regulator of having a clear scope of practice;
- views about whether or not any categorisation was desirable and/or feasible, questions about how the categories had been developed and the links to the evidence base, the need to be careful to avoid confusing what osteopaths treat with who they treat and how they treat, and concerns about particular approaches being sidelined;
- that the nature and focus of osteopathy is holism, the use of touch, seeing the individuality of the person and putting the body in the position where it can heal;
- disagreement about whether or not adjunctive techniques such as acupuncture, Cognitive Behavioural Therapy, nutritional and dietetic treatment, herbal and homeopathic remedies and detailed ergonomic advice are osteopathy or not;
- that defining a scope of practice in this way for osteopathy was an impossible task;
- the potential consequences of defining a scope of practice on the way practitioners might practice, insurance cover and the profession

Common themes and conclusions

Common themes which emerged in both the questionnaire data and the discussions at the regional events were that although many in the profession could see that defining a scope of practice might highlight what is special and unique about osteopathy and had the potential to bring greater understanding to the public, patients, and other healthcare professionals about what osteopathic practices and

osteopathy have to offer, it might not be feasible and could have negative consequences. Questions about feasibility related to a concern that the activity of defining is intrinsically reductionist and therefore not congruent with the holistic philosophy of the profession. The negative consequences suggested were that having a defined scope could potentially restrict innovation in and development of the profession as well as change case mix and impact on indemnity insurance etc.

There was particular antipathy to the three categories proposed in the consultation document. There appeared to be less resistance to defining a scope of practice if it was focused on principles rather than treatments and was consciously inclusive and embraced all parts of the profession.

There was a strong request for much more consultation about both the desirability and feasibility of developing such a framework.

Introduction

The Osteopathic Practice Framework consultation document set out a broad framework intended to describe the general principles which inform the osteopathic perspective on healthcare, indicate the potential types of clinical practice that may be encountered, and classified osteopathic approaches into those more commonly used and those less so.

Over 4,500 copies of the Osteopathic Practice Framework consultation document were circulated i.e. a copy to all osteopaths on the Register as well as other stakeholders. The consultation document was also available to download from the GOsC website. This report has been developed from an in-depth analysis of the 306 consultation questionnaires received and the data from the transcripts of the debates at the regional consultation events. The report has been prepared by Abigail Masterson and Alexandra O'Hanlon of Abi Masterson Consulting Ltd. for the General Osteopathic Council (GOsC) to inform its ongoing work in this area.

The same principles identified in the recent report to GOsC on its revalidation consultation were adopted here¹ namely:

- analysis was systematic and comprehensive
- the interpretation presented in this report is well supported by the data
- the full range of perspectives expressed in both data sets is reflected.

The report begins by briefly outlining the background to the consultation. The consultation process is then described. The analysis of the questionnaire responses received and a thematic analysis of the issues and questions which arose at the regional consultation events follows. Finally the limitations inherent in the analysis and issues for further consideration in the GOsC's ongoing work in this area are presented.

Background

The Osteopathic Practice Framework consultation document outlined the GOsC's perception of the current lack of clarity around what constitutes osteopathic practice and the challenges which this raises for GOsC as a regulator and the potential confusion it provokes amongst the public. The consultation document set out a broad framework intended to describe the general principles which inform the osteopathic perspective on healthcare, indicate the potential types of clinical practice

¹ Masterson, A. and O'Hanlon, A. (2009) Revalidation for Osteopaths. Consultation report presented to Council on 18th November 2009

that may be encountered, and classified osteopathic approaches into those more commonly used and those less so.

The consultation process

All osteopaths were sent a copy of the Osteopathic Practice Framework discussion document and a questionnaire (both were also available on the GOsC website). At the regional conferences key figures in the profession role-played a debate which presented a range of views for and against establishing such a framework. Specific consultation with osteopathic education providers (pre and post-graduate), the National Council of Osteopathic Research (NCOR) and the British Osteopathic Association (BOA) was also undertaken. The Consultation closed on the 30th June 2009. Over 1000 osteopaths attended the regional events and 306 questionnaires were received.

Analysis

As identified earlier in this report, the principles used in the recent analysis of the GOsC revalidation consultation were adopted for the analysis of this consultation data too². All data from the questionnaires were entered into a SNAP database and the discussions recorded at the consultation events were transcribed in full. Content and thematic analyses were carried out on the data from both data sets. Extensive direct quotes from the data are used to give a vivid and rich picture of the types of responses received; to help put the quantitative findings in context; and to demonstrate the diversity and strength of feeling about particular issues.

Findings

The findings from the questionnaire data are presented first followed by the findings from the discussions at the regional events.

Questionnaire Data

This analysis of the questionnaire data is presented in themed sections, which are organised to correspond with the list of questions posed the consultation document. The percentages in each section should be treated with great caution as some respondents ticked yes but then gave a very critical or negative response, others indicated in their free text that they had ticked yes or no to the question they thought they should have been asked rather than the one actually asked and so on.

² Masterson, A. and O'Hanlon, A. (2009) Revalidation for Osteopaths. Consultation report presented to Council on 18th November 2009

Defining the scope of osteopathic practice

62% of questionnaire respondents agree that there is a need to define the scope of osteopathic practice.

Benefits

The perceived benefits associated with defining the scope of osteopathic practice include:

- bringing a greater understanding to the public, potential patients, and other healthcare professionals about what osteopathic practices and osteopathy have to offer;
- it would identify what is special and unique about osteopathy;
- it would offer greater safety for osteopaths and patients and that this would increase osteopathy's acceptability to the NHS;
- it would help osteopaths and the profession promote what they do better;
- it would encourage cohesion within the profession; and
- it would support regulation.

The following quotes illustrate these points.

"It would bring clarity to patients about how and what conditions we treat and what type of person or condition would respond to our treatment; many people are still confused as to the difference between physio, osteo & chiro and can't decide who treats what better..."
(Respondent 11)

"To ensure that as a profession we encompass & respect the diversity of approaches that make up osteopathy. To ensure boundaries are clear so osteopathy does not merge with other therapies & lead to confusion with patients & health care bodies including GPs & insurance companies. To ensure other healthcare bodies understand the scope of osteopathy."
(Respondent 25)

"It will bring out our unique way of helping patients to improve their health on any level." (Respondent 239)

"Maintaining standards & safety"(Respondent 24)

"If we are to be seen as professional then we cannot exist without a clear statement of who we or what we do. Not just for marketing but for public confidence and safety" (Respondent 268)

"It enables people who do not know about osteopathy have a clearer understanding. It also may give the government an insight and therefore

push the boundaries in suggesting to open practices within the NHS – or at least accept osteopathy as a profession”. (Respondent 70)

“Definition of osteopathy is important in order to market our profession to the public and show how we differ from other manual therapists.” (Respondent 159)

“Cohesion within the profession. Definable parameters for clinical inclusion under the title & limits of competency. Something to “advertise” what we do to patients/ other professionals.” (Respondent 33)

“Greater regulation by health care providers and the public in general which in turn would promote the growth and relevance of osteopathic approaches and treatment/health care” (Respondent 68)

Disadvantages

The disadvantages associated with defining the scope of osteopathic practice identified by questionnaire respondents are that it would:

- inevitably be too narrow and limit the scope of practice;
- the activity of definition is itself reductionist and thus counter to the underpinning philosophy of osteopathy and therefore impossible;
- be restrictive and will not allow the profession to grow and develop;
- would change the case mix that osteopaths treat currently;
- is likely to result in inappropriate misconduct and legal challenges; and
- would divide the profession.

Some illustrative quotes from the data are presented below.

“If the scope is too narrow and restricting it may limit the benefits osteopathy has to offer and limit its growth and development as a profession.” (Respondent 136)

“It may make some professional bodies (e.g. obstetricians) try and limit who we treat for what e.g. pregnancy & newborns, which in my case is 1/3 of my patient list!” (Respondent 141)

“A ‘scope of practice’ limits the possibilities of what osteopathy can offer. This reductionist approach can not represent a holistic medicine. Osteopathy is a philosophy not a list of techniques” (Respondent 2)

“We would have less challenging cases i.e. hidden pathologies minimising muscular disorders as patients would have a clearer

understanding of when to see us – clearer boundaries = more confined scope of practice” (Respondent 11)

“Possible pressure on persons who don't meet with the norm – perhaps with legal ramifications which limit the scope of osteopathy” (Respondent 48)

“Some osteopaths may see this as the first step in limiting their scope for practice – could be used against an individual in legal proceedings i.e. that’s not within your written scope of practice as laid down by the GOsC” (Respondent 256)

“Limits the scope and development of osteopathy and potential for benefit to patients. Inhibits provision of patient centred approach in favour of symptom based approach. Could polarise & divide practice” (Respondent 176)

“Too narrow, may divide profession up in the future and restrict our treatment approach to individuals and certainly not holistic.” (Respondent 1)

A number of respondents support the need to define the scope of practice in principle but not in the way put forward in the Osteopathic Framework Consultation document e.g. respondent 108:

“A tightly rigid definition of osteopathic practice would aid the GOsC in its regulatory role and provide an easily understandable explanation for potential patients and public.”Osteopaths” would be in less doubt about the regulatory framework in which they practice ... [however]... A rigid definition of the scope of practice may promote some practitioners registered as “osteopaths” to resign from the register in order to continuing practicing in a less defined environment calling themselves by some other title.”

Approach to setting out a scope of practice

65% of the questionnaire respondents agreed that the overall approach proposed to setting out a scope of practice seemed to be sensible. Some respondents were very supportive of the proposal and the document:

“I think it has been done sensitively and sensibly” (Respondent 286)

“Document superb.” (Respondent 77)

Many of those who disagreed with the approach proposed to setting out a scope of practice, rather than proposing alternative approaches tended just to give reasons why they disagreed with the whole idea.

“Osteopaths are already regulated by strong knowledge, ethics and clinical based criteria. This along with CPD updating & development provides adequate public protection, yet allows beneficial diversity of approach.” (Respondent 176)

“There is no need to publish a detailed description of osteopathic practice. We do a wide variety of things. Osteopaths are qualified to use their clinical judgement” (Respondent 170)

“If the answer to '1' is no – no need to define an alternative, right?!” (Respondent 132)

“AT Still's definitions are good enough for me” (Respondent 121)

The few suggestions offered were:

- starting with principles rather than treatments
- adopting an inclusive approach that embraces all parts of the profession
- asking osteopaths what they do
- looking at what is happening internationally
- making the document more succinct
- taking a different approach to consultation

“Not using treatment approaches as a way of defining osteopathy. It is the principles behind the treatment that define osteopathy” (Respondent 35)

“Osteopathy is what an osteopath does. It is philosophy based, and doesn't fit in to a system based approach. Even if this might suit the NHS & patients – it would not be osteopathy” (Respondent 125)

“...Remember "osteopathy is a broad church!" (Respondent 31)

“You do not reference how you got to your conclusions about what osteopaths do. This might have been a better place to start. We should be looking at the whole of the profession worldwide – not just in the UK...” (Respondent 202)

“If you asked say 100 representative osteopaths for a narrative version of their view you would get a far better take on the subject” (Respondent 161)

“Too wordy and repetitive – make it shorter and people are more likely to read it. Avoid difficult to interpret diagrams (e.g. fig. 1)” (Respondent 142)

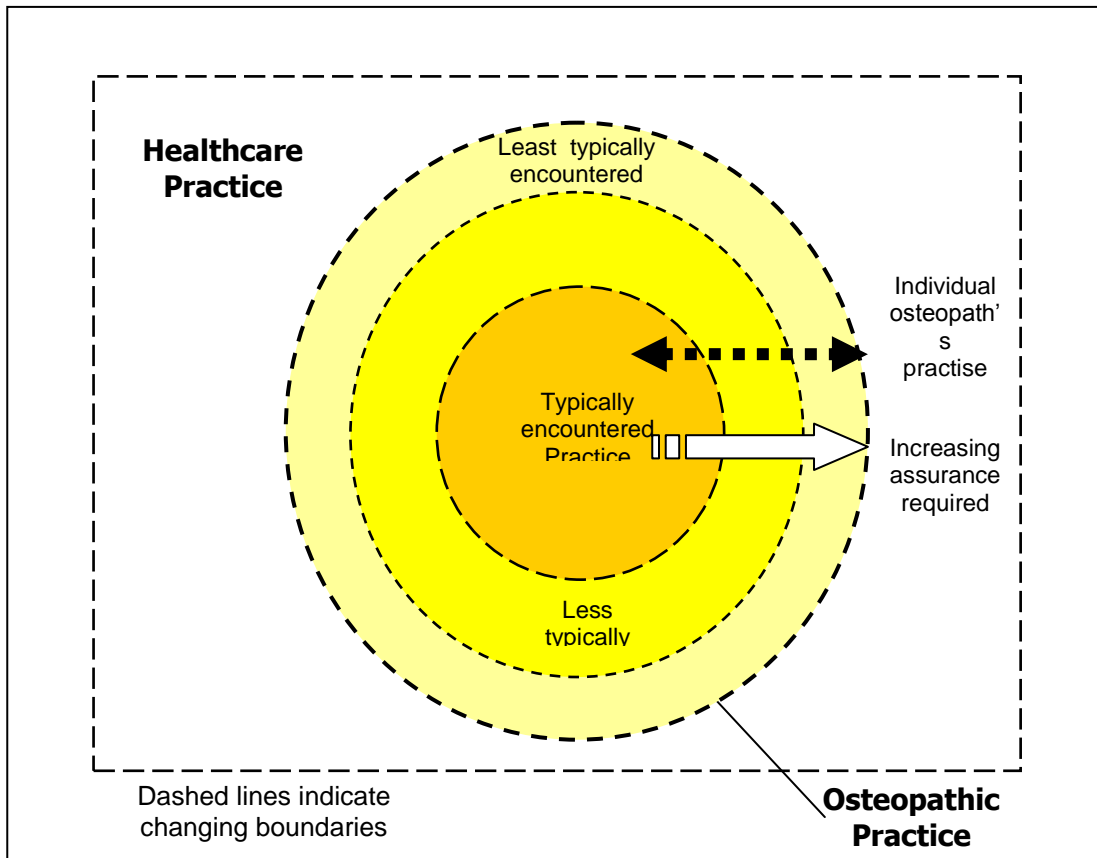
“Although the concept of clarifying scope of practice is sound the approach adopted could be improved. There hasn't been enough time for proper consultation and there appears to be a push towards narrowing scope of practice. A better approach would allow more time for proper debate and a questionnaire that was longer than 2 pages of A4 and provided more space for suggestions and comments.” (Respondent 138)

The categorisation

The discussion document proposed dividing the types of approach that may be taken in osteopathic practice into the following three broad categories:

- A.** Typically encountered osteopathic practice – the features of the typical experience most likely to be had by patients when seeing the majority of osteopaths.
- B.** Less typically encountered osteopathic practice – the features of osteopathic practice that may be experienced when seeing osteopaths who practise using treatment techniques less commonly used.
- C.** Least typically encountered osteopathic practice – this may involve very much less frequently practised approaches, new emerging areas of treatment or an osteopath practising in a specific area only. It may be related to the type of patient, the type of treatment used or the type of problem seen.

It presented a consideration of these different approaches in light of the different risks each might pose and offered a schematic representation reproduced overleaf:



This categorisation was highly contentious and very unpopular and only 48% of respondents agreed with it.

The main concerns seemed to be that what is one osteopath's "least typical" could be another's "typically encountered", that the categories implied a hierarchy of worth or value, that categorising in this way will become a self-fulfilling prophecy, and how the GOsC developed and decided the categories.

"Why is there a need to categorise practice? Is there a typically/less typically/least typically encountered patient? Treatment is patient not practice orientated. I have no idea – what is this based on? What is the rationale for linking the groups in each section? E.g. osteopaths working in a "least typically encountered practice" working with babies would use the cranial techniques which are listed under "less typically encountered". To me, adjunct treatments are not osteopathic treatments & should not be included as such: and why are elite athletes a separate category from any competitive sportsman or woman." (Respondent 6)

"No categorisation is necessary. Categorisation risks implying hierarchical value to certain techniques, much is inaccurate. It's not the technique or approach that makes a difference, it's the individual" (Respondent 238)

"Osteopaths have long been saying 'we are not just backs'. To categorise the typically encountered practice as in 'A' places osteopathy primarily in the musculoskeletal/basics realm. Thereby creating a self fulfilling prophecy that most patients will be that of sort and therefore other treatment modalities are rarer and encountered less often. But many osteopaths have less common skills but use them less often due to the type of patient perceived as being suitable to see an osteopath" (Respondent 294)

"You do not reference how you got your conclusions about what is 'typically encountered' etc. I would like to see what statistics informed these definitions. You also do not reference what has actually been researched elsewhere other than osteopathic practice. Why should one provide more reassurance for – say – Laser Therapy (or some of the other electrotherapies) – which you have put down as something "less typically encountered" when there is considerably more published research on Laser Therapy than on any aspect of osteopathic practice? This modality has had research published in journals that have much higher ranking than any osteopathic journal e.g. Pain, Nature; just because something is less typically encountered in osteopathic practice, does not mean it is more typically encountered throughout medicine". (Respondent 202)

"...On whose judgement/evidence was the definitions defined. Wait for NCOR research into actual practice before doing this." (Respondent 22)

Some respondents saw some of the techniques described being very fringe and suggested that their inclusion might have negative consequences for the profession over all.

"This section is difficult for me to answer as I try to stick with a scope of practice which is well supported by a scientific and clinical evidence base. I find some areas of osteopathic practice as ridiculous & unacceptable" (Respondent 12)

"I would rather that practitioners of craniosacral or involuntary mechanism techniques were called something different as a lot of them do very weird things and don't help the reputation of osteopathy" (Respondent 83)

Another commentator noted:

"I haven't seen anywhere what osteopathy doesn't include? Is this to keep the scope wide?" (Respondent 300)

Types of practice included in each category accurately reflect current practice

Only 49% of the questionnaire respondents agreed that the types of practice included in each category accurately reflect current practice but most of the comments seemed to relate to their division into categories and how the list was developed rather than whether their inclusion was appropriate.

"Treating children & elite athletes. Are commonplace and should be in Cat B. Cranial technique also should be moved to A" (Respondent 30)

"Cranial osteopathic work is being used by a high proportion of the profession. Post graduate courses in cranial osteopathy have been the most attended in (by days per size per year) than any other post graduate course in the profession. They should be in the 'core' group" (Respondent 95)

"Didn't realise that the use of dry needling, ultrasound & myofascial trigger points were used so infrequently as to be placed in the third category; in the practice I currently work in, we use these methods on a daily basis & would consider them to be part of the first category." (Respondent 185)

"How do you or I know? I am not aware of any survey having been done" (Respondent 49)

"I only know what happens in my practice & those of my closest associates. I cannot possibly know what the situation is around the country have you studied this?" (Respondent 145)

"I think acupuncture is far more widespread than you suggest, possibly even should be in 'most likely' category. Every osteopath I know/work with does it now. Suggest with re-registration forms you conduct a survey to see which treatments are actually appropriate for each section" (Respondent 297)

There was also a suggestion that what techniques osteopaths use linked to what they were taught in their original pre-qualification programme:

“It depends which osteopathic education institute you went to as to what types of practice had emphasis. Perhaps alternative grouping would be where the osteopath graduated from” (Respondent 54)

Additional areas/techniques suggested for inclusion were:

- Buteyko (breathing technique)
- Facial release
- Neuro linguistic programming
- Manual techniques with the intention of indirectly treating the somatosensory cortex (homunculus)
- Prolotherapy
- Harmonic technique.

Some respondents suggested that it would be better to have a list of what is not included:

“I would add what does not constitute osteopathy i.e. applied kinesiology & the types of bizarre diagnoses that go with this” (Respondent 74)

“Personally I would remove any reference to use of electrical machinery – osteopathy is a manual therapy” (Respondent 96)

“If people practice acupuncture, Pilates ... these are distinct from osteopathy & and should not be included in your description beyond the fact that practitioners may have a 2nd training” (Respondent 154)

Other comments

The final question offered respondents the chance to add any further comments. In the main respondents used this to restate their support or opposition for a framework of this type.

“A valiant effort, open minded & laterally visioned. I'm impressed but sure some will require it to be tweaked a bit” (Respondent 97)

“This is an incredibly dangerous program which will compromise the ability to use the “most appropriate approach”. It gives ammunition to all those who wish to compromise & circumvent osteopathy in the UK & around the world. The question is why is this being done in the first place? If you think this will help conventional medical practitioners refer patient to us forget it. There is a total lack of understanding of what osteopathy is and the sooner this is recognised by GOsC the better. This will not make osteopathy “friendlier” or understandable, just limited” (Respondent 86)

Those in support often acknowledged how difficult the task was but emphasised its importance. Many of those against requested more clarity about the purpose of a framework of this type, why it is being proposed and what it will be used for. A few respondents highlighted some potential but unintended consequences of establishing such a framework for example it might stifle research into techniques that are 'less typically encountered'. There were also some concerns about cost. Some respondents took the opportunity to comment positively on the consultation process itself but others were concerned about timing. Several respondents questioned whether or not this was really the business of the regulator.

"Thank you for doing a good job in getting this far, don't be disheartened, it needs to be done" (Respondent 73)

"I need to be clearer on the purpose of all this in the first place – is it for marketing mainly, regulation mainly, to satisfy government pressures mainly, to weed out what we consider to be those calling themselves osteopaths but not really practicing "osteopathy"? Please clarify to all the overall aim/ purpose" (Respondent 55)

"There is a danger that this process is being conducted back to front. Rather than defining scope of practice to fit in with the expectations of patients we should be positively educating the public about how wide and varied osteopathy is and how it can help many different people improve their overall health" (Respondent 138)

"I hope this exercise is not too costly in this present climate" (Respondent 107)

"In times of financial concern I really do feel producing a document in colour in this way is completely unacceptable, black and white photocopy would be just as good and so much cheaper" (Respondent 268)

"The document needs much work but the consultation event was encouraging!" (Respondent 33)

"I enjoyed the consultation meeting in Taunton – very well organised – felt that we were being listened to: I hope that is reflected in the revised "framework" document" (Respondent 131)

"If you are serious about consulting you need to include an SAE. Our registration fees should run to this" (Respondent 242)

"I do not see the need to rush this Framework through. Let us concentrate on the revalidation document first. There is far too much info with both

documents being rushed through. The framework document is very important & should not be forced on us” (Respondent 26)

“The document is entirely inappropriate the only way forward is to hand over the task to the post graduate senior osteopathic groups – by definition GOsC are not qualified to compose such a document” (Respondent 14)

Other issues raised were much more disparate and general:

- prescribing
- informing patients about the need to undress
- more information on treating pregnant patients

Analysis of discussions at the regional events

The debates at the regional events were clearly enjoyed by those attending the events. They did however, as debates are intrinsically designed to do, encourage a polarisation of views.

A considered analysis of the views expressed by the audience in response to the debates is presented below. As with the qualitative data contained in the questionnaire responses described above, a process of ‘content analysis’ was used to analyse the commentary on the debates. Recurring themes were identified and then grouped into a smaller number of broader themes which were used to ‘code’ the data and sort the quotes into categories. It is important to emphasise however that each of the debate sessions had a slightly different flavour and emphasis depending on the points made by the presenters which are likely to have had an impact on the comments made by the audience. Also the Chair often made suggestions and comments which then impacted on the discussions that followed eg asking about the QAA benchmark statement at the Gatwick, Manchester and Stansted events.

The issues raised during the debates by the audience rather than the presenters are now presented in themes below.

Being true to our origins

Impassioned pleas to remember and be true to the origins, philosophy and founding fathers of osteopathy occurred in all of the debates.

“...There’s an awful lot of stuff that osteopaths can do which is being left behind and forgotten. There’s some of it is probably not relevant, but some of it’s very, very relevant and I still use a fair amount of that in practice, and I’m still there, but I think we mustn’t forget our origins, our

philosophies, although they need changing and adapting. One of the biggest problems here is, what are we actually doing? And I think, going back to some of the old stuff, take the stuff that's good, leave some of the stuff alone, move on with the new techniques, and new approaches, but combine and do what works, it's as simple as that." (Birmingham)

Well, there are certain principles which we're taught - for example, the body functions as a unit, the health systems of the body are interrelated and dependent. I mean, I could go on. There are various examples. The body has its capacity to maintain health and disease. When conditions compromise the body's ability to maintain health, or external conditions do not allow it, then disease results. These are basic principles that we should refer back to. These are as developed by Andrew Taylor Still." (Stansted)

"...anyone can be treated with osteopathy, anyone, but I think we have slightly lost our way. So, countering my argument, maybe we do have to redefine ourselves, but we shouldn't lose sight of what Andrew Taylor Still was actually, really trying to do and that was to... it was a system of health care, not a system of treating back pain, which is what most people think we do and by doing that we have completely limited ourselves." (Glasgow)

"...Going on to the different techniques, whether it's cranial, manipulation - they're not necessarily osteopathic I don't think. You could have a cranial therapist who's not an osteopath, but he uses the same technique. You could have someone who sees the doctor for manipulation under anaesthetic, and he's not an osteopath. Osteopathy is the principles of osteopathy applied in the treatment of someone, so physiotherapists can use very similar techniques, but they're not osteopaths, because perhaps they're coming from a different direction. And so the technique does not mean the actual profession I don't think, and it's getting too bogged down with details of is cranial osteopathy, is manipulation osteopathy... the technique is a bit irrelevant, really. (Taunton)

"...But my attitude to this definition or otherwise of osteopathy is that really that comes down to the philosophy of osteopathy. I think that is crucial to our understanding of osteopathy. The other point that I really want to make is if we are medical practitioners of one kind or another, that we're engaged in primary healthcare, then we are general practitioners of osteopathy. Now correct me if I'm wrong, but I wouldn't think that a GP, a medical GP, would say that he's a specialist in any specific medical speciality. If he finds something that is outside his immediate area of treatment, he will refer to the appropriate authority. I think that's exactly what an osteopath should do, but I think the fundamental difference is one of philosophy. I would certainly be very reluctant to go down the route of defining osteopathy as simply a manual technique that involves

manipulation of the spine or peripheral joints, or indeed only related to the musculoskeletal system. We have a very poor understanding of all the mechanisms involved in what some osteopaths are treating with on a regular basis, albeit with what they refer to as ability, confidence, and getting good results. I would be very reluctant to confine this into a very narrow box which restricts us into – and I'm going to be controversial now – into what conventional medicine thinks osteopaths do. They treat backs.” (Manchester)

Although another commentator argued that it had to be more than just the philosophy that made an osteopath an osteopath:

“ It sounds like you could be calling yourself an osteopath based on philosophy, so you could have given up all manual practice and you could, for example, be just prescribing herbs. So a member of the public could ring up, make an appointment, and not have any manual treatment at all and just be given some herbs, and be thoroughly confused, go home, ring the GOsC and make a complaint.” (Gatwick)

And another doubted whether the principles were actually still unique to osteopathy:

“I don't think that the principles of osteopathy ... I don't think they any longer are distinctive to osteopathy. I think if you go back to the early 20th century, that may well have been true, but I think now these principles of homeostasis are pretty much generally accepted, even by the orthodox medical profession. So I actually don't think we can ultimately claim them as ours anymore.” (Stansted)

Stifling innovation and limiting practice

Concerns were expressed by commentators in response to the debate that by defining a scope of practice this would necessarily be limiting both of the profession and individual osteopaths and would be likely also to stifle innovation.

“I recently went to the Health and Wellbeing at Work exhibition in Birmingham back in March, and I went with a colleague who works in Leamington Spa. We were absolutely astounded at how the physiotherapists have made massive inroads into occupational therapy, condition management, and a number of areas, and this is because they have managed to make themselves rather broad based. I think that osteopaths, there's very few of us yet. We're, as you say, a very young profession. What we're going to do for the profession if we narrow ourselves down dramatically is to reduce the ability of future osteopaths to make inroads into these other areas where I think they can make a massive

contribution, especially in things like condition management which seems to be exclusively taught, at the moment, in postgraduate courses in hospitals. I think we are extremely well placed to be condition managers, and these are areas which are being used, for instance, in the government, in job centres, where people are on incapacity benefit where they can't work and they need to be measured. This work is being done by physiotherapists. Another area is workstation assessment. I've seen people have their workstation areas assessed very, very badly by people. I think osteopathic principles, the philosophy and principles, should be allowed free rein so that we can actually go into these other areas so that we make the osteopathic profession much bigger, where we can work in bigger areas.”(Gatwick)

*“...I do think we need to be very careful about limiting ourselves because people will limit us and other professions will want to limit us.”
(Birmingham)*

*“... therefore, within the scope of each individual osteopath's range of skills that have been acquired and developed over time, as does his perceptual ability, that scope of practice develops and increases within the individual as time goes past. It would be a horrifying thought after 20 odd years of practice of expanding one's appreciation of health and disease to have that capped by a standard set by a typical model of recent graduates.”
(Manchester)*

“And this is where we're growing and still growing. And sometimes I think we forget, or maybe the registering body forgets, you've only been around for 10 years. Look at the changes that have happened in these 10 years within the scope of regulation. How could you possibly expect us to be even at the beginnings of trying to define and limit where our great profession, in my opinion, because we help people to help themselves, we do get people better, somehow or other, maybe we don't know how, but we do, some people do.”(Glasgow)

Indeed many felt that what they as individual practitioners valued about being an osteopath was their broad scope of practice and that the intrinsic strength of the profession was its diversity.

“I think we're all appreciative that this has got to be done and it's really important, but over the years we've worked really hard to promote osteopathy as not just about treating backs and mechanical problems. I think, personally, that's what I'm most worried about losing, is the variety. I love my practice because I treat babies, I treat old people, people come in with asthma, they come in with headaches, and we've got the scope and ability to treat all of those things now. I'm very happy to go down this

avenue, but just to have the reassurance that we will still have the ability to do those things” (Manchester)

“The strength of osteopathy is in its diversity. There was a joke some time ago that a group of osteopaths are called a disagreement of osteopaths, and I think there’s a lot of truth in that. No two osteopaths will approach the same patient in the same way, and that is part of our strength.” (Stansted)

The need for an evidence base

Issues related to the evidence base for practice were also of interest to some commentators:

“I’m only concerned from the point of view that if we don’t do the things within osteopathy which we have some scientific base as being effective, then whilst we might want to go away and play with lots of other things, is it fair that our patients are paying for treatments which have no basis in any kind of science or showing efficacy? Kirkcaldy-Willis states that there are 27 good research papers that are done to a high enough standard to accept that manipulation works, and he’s a big orthopaedic surgeon in America, and as far as I’m concerned, therefore, I feel very comfortable in using manipulation as a mainstay of my practice. I am not comfortable in charging my patients money whilst I play around with some of the other stuff, for which I cannot understand how it may work or I have not seen any evidence that it might work. If I want to play with the patients, under those circumstances, then I don’t think I can charge them, because I’m trying to experiment, I’m trying to find out. If a patient’s paying me money because their back is sore and they want me to try and get them better so that they can get back to work, or whatever, then I feel duty bound to use those techniques, which the evidence shows works.” (Glasgow)

Although opinions differed as to whether or not there could or should be an evidence-base for osteopathy or all the techniques used by osteopaths:

“It seems to me that NICE are very keen on evidence based research and evidence for treatment. As far as I’m aware, the evidence for osteopathy relies on, or is based on, evidence for specific techniques, as a colleague said, evidence for the guideline is for manipulation of lower back pain between a certain period of time. That isn’t osteopathy, it is osteopathic. There’s no evidence at all for osteopathic principles or osteopathic philosophy” (Stansted)

"...I think fundamental to both is that osteopathy should be based on reality and as evidence based as possible and drawn from both the social scientist and the epidemiologist as well. And not anecdote alone, and not anatomy and physiology created to justify our approach." (Gatwick)

Similarities and differences with other professions

At all of the debates there was discussion about the similarities and differences with other professions, in particular physiotherapists and chiropractors, and the importance or not of this.

"I recently went on a CPD weekend at the Royal Free which was, the group consisted of 40 physiotherapists and 2 osteopaths and it was actually a presentation by the NIO group. I don't know if anybody else has been along to the mobilisation of the nervous, of the peripheral nervous system CPD groups? It was like sitting in an osteopathic lecture, there was so much similarity in the philosophy and the style of treatment that I felt, and I was really impressed by the standard of presentation and by the working with the physios over the 2 days, I felt really joined up with them, and not separated, and had great discussions with them, and what they learnt in their undergraduate training and how they treat it. I felt that there was far less difference between us than I had imagined out of my practice, where I didn't come into contact with these people, and just had old fashioned ideas about what they did." (Birmingham)

What I do find unreasonable at the minute, and tomorrow, is an osteopath training physiotherapists in Grade 5 manipulations. We've been through a conversation this morning of how risky we can be in terms of whatever you're calling high velocity thrusts. How can a six day course to a physiotherapist... we might have our name protected, but the patient is the person who needs protecting. How do you protect the patient from the physiotherapist who's had a three day course from an osteopath in the future?" (Taunton)

"I think that the only way we will differentiate ourselves from physical therapists, or physiotherapists - and I came from a physiotherapy background - is to demonstrate our osteopathic content, by our principles, and our practice, and our philosophy, so that if we let ourselves be known by the way the principles are applied, then we will follow and give osteopathic treatment naturally, but it will also give us a definition that separates us from other physical therapists, musculoskeletal therapists." (Gatwick)

Public expectations and the value to the regulator and the NHS

The challenge of meeting the expectations of the public and other professions and the value to the regulator of having a clear scope of practice was recognised as were concerns about why osteopaths had to do this and other professions did not.

"I know I've heard it said that there are some patients who have complained, not about me, but where people have counselled them and they haven't enjoyed it very much because all they want the osteopaths to do is just crunch a few bones in their back and then they think they'll feel better. The fact that they go back time and time again means that they haven't really been treated properly because somebody hasn't got to the problem, which probably means that they need maybe somebody to sit down and talk about what their problem is. How are you going to find the boundary in this very complex area?" (Gatwick)

I'm just going to now speak up for the osteopaths who treat the animal side. We apply our osteopathic principles and philosophy to treating the animals, and to me it's the individuality and the fluidity of osteopathy that makes it such a success over all the years. But the interesting thing is that the veterinary profession are very interested in actually knowing what is osteopathy. It's very hard to give – and I don't like the word 'definition' – but perhaps to just explain where we are and our differences between the chiropractors and the physiotherapists. I'm very lucky to be quite involved, and we're going to have a big consultation with the British Equine Veterinary Association, and their most interesting thing is lots of people are going around treating horses specifically, massaging, they're using cranial sacral techniques. The trouble is, lots of people will describe the techniques. What the vets were very interested in is that we have formal training, we belong to a very professional body, we have to have CPD, insurance and ethics, and not only can they law the veterinary profession, but also our own association can keep us under control. And I would probably just like to see the top and bottom ones come out of that 'least typical encountered practice', because as the gentleman said in the front, we're all treating... I think trying to make it too specific. The other thing about the care of animals is there is a lot of research and progress, and I think we can learn a lot, especially from the stem cell theories and everything else, through the animals, because unfortunately we can then kill them and actually dissect and get the research. We can't quite yet do that with our athletes, so I think that's something which is very important and I think it's a very exciting aspect as well." (Stansted)

"I think one problem I have with the idea of creating a practice framework, I can see the regulatory need for it, is you mentioned yourself this idea of some people thinking osteopathy is everything that you do. I don't think

that's right. I think rather than defining osteopathy, you have to think, 'Is the intervention that you make with the patient osteopathic, and how is it that what you're going to do, how is it going to be osteopathic?' And without some principles that help you define your thinking and your treatment approach, whatever you do cannot be osteopathic if you don't define the principles by which you make the decisions. So I think that's a thing. I'd like to see in the practice framework some definition of principles of osteopathy which allow us some flexibility in how we approach it." (Stansted)

"...what I'm going to say I think is not for me, but it's for the future of the profession. Medicine doesn't define what it is, why should osteopathic medicine define what it is? The general osteopathic council believes that's not the same thing as saying the profession believes, the government may want us nicely pigeon-holed because it does suit the regulators. If you've got regulations, you can control them, if you haven't it makes it much more difficult, I agree with that, but that is the beauty of what we do. We have no idea what sort of osteopaths we're going to have, or what they're going to be interested in, or what lines they're going to follow in the future. But it is our duty to maintain the right of people coming in the future to be able to go down whatever pathway they're going to go down". (Glasgow)

One commentator suggested that having a defined scope of practice might make it easier for osteopaths to get work in the NHS:

"...a lot of young osteopaths find it difficult to get a lot of work and are looking towards the NHS as future employers. So, I think it's quite important in that case to have to define osteopathy so that it will be easier for those people to enter the NHS." (Birmingham)

The categories

As in the questionnaire data there was a lot of comment about the categorisation proposed. This included views about whether or not any categorisation was desirable and/or feasible, questions about how the categories had been developed and the links to the evidence base, the importance of being careful to avoid confusing what osteopaths treat with who they treat and how they treat, and concerns about particular approaches being sidelined:

"I'm very concerned about the division of typically and less typically encountered practice. All of this is typical practice, it's just some is used more often than not. The less typically that you've got written up there are not osteopathic techniques, not this one, but the next slide. Then osteopathy, osteopathy is a manual therapy, it's not acupuncture, it's not

herbal and homeopathic remedies. They're adjunctive techniques, but they're not osteopathic techniques. And so, therefore, we're getting a division of typically and least typically encountered techniques, but who's to say whether an MET is going to be more popularly used than functional in practices? More so than craniosacral, it's entirely up to an osteopath and their understanding of the person in front of them and not the disease or the technique they wish to use. And I'd like to see this typically and less typically encountered practice actually removed." (Glasgow)

"...I would support [name] in what he said, which is the things that are in the third category as least likely to be encountered are indeed the things with the best evidence, and that I think is a very curious position that we find ourselves in. I wonder how people who support cranial treatments and visceral treatments are going to justify them their patients, and I hope that they find a way to. I would like to see osteopathy have a broad church, but I think there is a responsibility on us to provide the treatment to our patients which is effective, and to measure it, and to see that it works." (Stansted)

"...I think it's important that we don't confuse the range of what we treat with how we treat? I think there are two, we have two separate issues. One, if we say that we have apparently a core area of what is treated, as being muscular skeletal problems, that's not necessarily because that's what osteopathy is only about. It's because, as they say, there's a lot of it about. There is nationally an enormous incidence of back pain and that other profession; other health care professions are not able to address this..." (Birmingham)

"I'm really glad to hear that you're actually going to get rid of those titles because..."

[EG – Rather we've had representations to do that.]

...Oh, right, okay. Representations to do that. Well, okay, because you've got up there 'expectant mothers and newborns'. Now I was taught at the BSO and I was actually taught that osteopathy is a treatment that is available for everybody from 0 to 90. Now least typically, as a colleague pointed out to me. I see expectant mums and newborns every day of my working life, but I also see 80-year-olds with arthritic knees. So to actually put a whole group of people in a 'least typically encountered osteopathic practice' is, I think, out of order." (Manchester)

Reading this document, I felt very much that the sort of core of my practice might be sidelined, but I also feel like I had a very, very good undergraduate education in cranial osteopathy, the treatment of children and babies. And I've done a lot of post-graduate work and my patients

are my teachers, and I think it would be an enormous loss to the core of osteopathy if we don't embrace the cranial side of things equally as much as the manipulative side, and I appreciate there are some who do and some who don't. It is not overriding but it is one of the things that we hold as unique as a profession from physios and chiropractors. So whilst I appreciate everything that's been said, this document may need quite a lot of modification. I would like it to be significantly more inclusive of the...I do both, I do manipulative and cranial, but I would like cranial not to be quite so sidelined. [Applause] (Taunton)

Contradictions were also highlighted:

"Right. I have a small problem; it's only a little one. I'm easily confused; I'm like the bear with very little brain. It says, Point 1 of the Generally Treated things, the General Guide, 'Problems relating musculoskeletally and the nervous system across the age range, from young children to those of advance years.' But it seems to say also, under the least typically encountered osteopathic practice, 'Treatment of children,' are they not young children with musculoskeletal problems? ... [Laughter and interjection from the Chair] It gets better. Point 2, Sports Related Injuries - which also, interestingly enough, is under the least typically encountered osteopathic practice, 'Treatment of athletes.' So is Work Related Injuries, with particular occupational causes. So is Impaired Function of Breathing, under 'Treatment of Respiratory,' also least typically. And finally, Pain and Impaired Function for Pregnancy, which I believe is Point 1 of Expectant Mothers. Now, [laughter] I'm just slightly confused, as a patient - I'll read this as a patient rather than an osteopath - it says here, 'If I go to an osteopath they'll treat all those,' however, 'If I go to an osteopath who treats all those, they shouldn't do because it's only practiced by a small number of osteopaths.' [laughter] Can somebody please explain which way round it is?" (Gatwick)

"...It struck me that you can have a practitioner working entirely within the typically encountered osteopathic practice list there, who's actually not an osteopath at all, they're a physiotherapist, or a sports massage therapist and that's one of my problems with it, is that it doesn't actually define osteopathic practice, it just describes techniques that lots of different people use in lots of different spheres." (Glasgow)

One commentator recommended learning from other countries and in particular New Zealand:

"I was just wondering whether you had looked at other countries and what they had done with their scopes of practice. I remember going through this whole process at length in New Zealand and I think it was quite a

good one, actually. It mentioned the core principles, it mentioned what was taught at schools, it mentioned that it was a manual therapy, and I think looking at what other people have done and where they've been successful and where they haven't, where they're happy or not, would be very helpful in this process.” (Gatwick)

Another offered a pragmatic way forward (which seemed to be quite popular listening to the general noises of agreement and applause that follow on the recording):

“I just wanted to offer a very general way forward. I think it's very important that the first part of any osteopathic scope of practice document should include our principles and our history and our enlightenment, so to speak. The second part should say, not the osteopath will do such and such, but an osteopath may treat structure in order to improve function with their hands by doing any of the following, and we can talk about what comes top of the list and what comes bottom of the list, but it should all be the same list.” (Stansted)

The nature and focus of osteopathy

Some key themes about the nature and focus of osteopathy emerged at the debates. These were holism, the use of touch, seeing the individuality of the person and putting the body in the position where it can heal.

“... and I think we should stick to the general principle which is very simple, that osteopathy is hands-on and treats the whole patient, the whole person – sorry, I'm losing the thread here – and not to be broken down into techniques. And the principle of osteopathy is all you need in order to define it.”(Taunton)

“Osteopathy is really the skill of touch. It's educated, it's discriminating, but it's really nursing a patient through a condition. It may be physiological, it may be psychological, but it's really the contact with the patient with caring, thinking, reflective hands through the sense of touch.”(Gatwick)

“They are only individuals. So, when I see a patient I don't have a general, the same in front of me, I have an individual and it's not a thing either, it's a living process. So, what might be accurate and appropriate for that person, might be very, very unique to that person, so I agree with what you say there, I can't exclude anything. It doesn't matter if 3,000 people in Germany last year benefited from cervical adjustment, that doesn't mean anything to me when I have a living process in front of me that

might need something very particular. That is for me the challenge of osteopathy as well, we can't... it's down to how we view a body, and what is a body? It's not a thing, it's a living process." (Glasgow)

"Well, I've got a number of points to make. I look at this in a very different way, be it osteopaths, chiropractors, physios, masseuses, whatever, what are we actually working with? For a moment, forget philosophies, forget techniques, we're working with the human body, the anatomy, the physiology, so it's not a surprise that all the different modalities, as they find what works, seem to move together. And like the lady was saying earlier about how the physios seem to be doing very similar things to osteopaths. So, I think the first thing is what we're working one hasn't particularly changed that much. What we need to do is to take the best of what we find what works, develop new techniques that are improvements, but not to forget the old stuff because a lot of that is still good. That's the baby in the bath water and I'll go onto that in a moment. The other thing I was going to say, as an osteopath, I can honestly say to you here, I have never, ever got anyone better, never. The healing power of the body gets people better. We put it into a position where it can heal, it can help itself. Well, actually, we don't really heal people, we put their body in the position where it can. And I think we mustn't forget that, it's not about the specific technique, it's what are we trying to achieve as an osteopath? What are we trying to do here? That's to enhance the body's healing power in whichever way we need to do it. These days I find a lot of people, they get better if they just go home and rest and relax. Do a bit less in their lives that often is very helpful." (Birmingham)

Adjunctive techniques

Whether or not adjunctive techniques such as acupuncture, Cognitive Behavioural Therapy, nutritional and dietetic treatment, herbal and homeopathic remedies and detailed ergonomic advice are osteopathy or not, also provoked much comment.

"Can I say that these adjunctive treatments, acupuncture is not osteopathy. It takes a lot of training, a great deal of training, then you become an osteopath and an acupuncturist, and you advertise yourself as such, and you are answerable to the Acupuncture Association. Herbal and homeopathic medicine, herbal medicine, National Institute of Medical Herbalists, long training. I did four years on homeopathy, long training. That doesn't make me an osteopath, it makes me an osteopath and, if I wish to use it, a homeopath. We should define the fact that we have had training and are responsible for that training. You do not learn acupuncture in osteopathic school, if you take it up as a subsidiary or a

complementary, great, wonderful, but do the proper training. I once crossed swords with a doctor who was publicizing that we were over trained; he could teach doctors osteopathy in two weekends. [laughter] He's not an osteopath; he has nothing to do with osteopathy. Let's define what we do, let's be proud of osteopathy, and if you're an acupuncturist, be proud of acupuncture, but advertise yourself as both so that the patient knows what they are going to." (Gatwick)

"...osteopathy is a manual therapy, it's not acupuncture, it's not herbal and homeopathic remedies. They're adjunctive techniques, but they're not osteopathic techniques." (Glasgow)

"In the interest of clarity, the list which we see before us is really very unhelpful. 'Osteopathic practice includes acupuncture' – acupuncture is not osteopathy and nobody would say it is. Homeopathy, a very fine discipline in itself, is not osteopathy, and nobody would say it is. Cognitive behavioural therapy is not osteopathy. That's a very unhelpful list, and I think we would all agree on that." (Taunton)

"Now just talking of my practice, firstly, because I started practicing in the dark ages, there weren't courses in naturopathy or nutritional therapy or homeopathic courses around that time, so I've had to develop an osteopathic view on how to work within nutrition and homeopathy. Just as an example for using the pulses, for example, will actually take me to where I actually put my hands on a patient to actually start working with the involuntary mechanism. So it's the acupuncture that actually tells me where to work. Now there is not an acupuncture course or qualification I could get that would actually give me a qualification that would allow me to do that. So I've always argued that that is within the remit of osteopathy. Similarly, and I actually teach homeopathy, without a qualification, and have done for a long, long time, and I use my palpatory skills to tell me how to differentiate and diagnose between say three or four possible remedies, and I actually use those remedies on the patient to actually feel how it changes tissue state. So I claim that is not an adjunctive therapy; I'm using the principles of osteopathy to expand the practice into the areas of need that my patient's tissues actually tell me they need, in the same way as someone would decide to do a high velocity thrust technique, or what I call snap, crackle, and pop osteopathy. So it's very important that we actually consider that over the years there are many ways of using these type of techniques within the philosophy of osteopathy, and they're not adjunctive. It's a question of choice of the therapies about whether they actually use them if they're actually listening to the patient's tissues and using that as a differential diagnosis." (Stansted)

An impossible task

Many suggested that defining a scope of practice in this way for osteopathy was an impossible task:

“Can I caution against definitions. As we’re talking about philosophy, I hope we all know what Wittgenstein said about definitions. He pointed out that you can’t make a definition of a game, that games have a family resemblance. We will spend a lot of time trying to define osteopathy, it’s a family of different things, and we’ll never, ever reach a clear definition.”
(Taunton)

“...you can’t get two osteopaths to agree what osteopathy is. So, why on earth do you think we would benefit from a more clearly described, defined scope of practice, is beyond me?” (Glasgow)

Unintended consequences

Concerns associated with defining a scope of practice were also raised about potential but unintended consequences on the way practitioners might practice, insurance cover and perhaps even result in the total break up of the profession.

“I think if we adopt the second, [...] position, will we all end up like physiotherapists who are now so frightened, they’re all doing defensive practice as they’re so frightened. Although they specialise in musculoskeletal medicine actually most of them now don’t even touch their patients they put their symptoms into a computer which then gives them an exercise sheet. Is that what’s going to happen to us as well?”
(Gatwick)

“I have a slight concern on a slightly more practical basis. If we go down the route of the three different sections, if you like, of most to least typically encountered practice, in terms of our professional indemnity insurance. Will it give the insurers any reason to start to say to us, ‘What sort of practice are you in? Which of these categories are you in?’ and therefore, if you’re in the least typical category, perhaps we’re going to say, ‘There’s a bit more risk to your practice. We’re going to make it more expensive for you.’ Just a concern, and I wanted to make the comment.” (Stansted)

Following on from that point about the definition of osteopathy, we’re going right back to the argument, I’d just like to say that there’s a risk of the whole osteopathic experience of patients being fractured. As osteopaths, we shouldn’t underestimate our colleagues. People with a bit more of a bias towards cranial shouldn’t underestimate the structural

colleagues who aren't all a bunch of mindless Neanderthals bone-setting and damaging patients, and at the same time, I think everyone likes to think of themselves as extremely scientific and evidence based, that we shouldn't fall into the trap of criticising people who have developed their cranial sacral skills as a bunch of wiffle-wafflers and Jedi knights. [laughter]. Osteopaths, whether you practice a lot of visceral techniques, cranial, or HVT, it's all part, I think everyone would agree, we're all taught that at school, and it serves no purpose, and we need to really stick together otherwise we will be lost. I work, similarly to my colleague, in a multi-disciplinary approach, and trying to define how different we are is very difficult when you're working with extremely conscientious physios, neurologists, every variety. We must be careful not to be arrogant in pretending that we've got a monopoly on holistic approach. Not to go on, but to say that I would say we're not complementary therapists; we're complicated. I would say that our strengths - or I am being a ginger - is that our strength, I feel, is not only in our communication skills, which as our colleague said is vital, and our palpation, and all the various techniques, but it's actually in our approach. It's a differential diagnosis. I feel working in a really quite tight schedule, that as the osteopath part of the team the patients are coming to me for a differential diagnosis, and I think osteopaths have got quite a good position to play there. If someone comes to us with a headache, we might be checking that it's not a hypertension, or we might even think it might be anaemia, whereas a colleague, a very respected colleague in the physio world might not necessarily have that in the first line of their differential diagnosis. So I feel that the way osteopaths look at it, whether they're assessing the involuntary motion, or the segmental analysis, Andrew Taylor still is agreeing with me. I think it's a differential and we can collaborate with our medical colleagues, with different paradigms, with no problems at all, and if we share their concern about passing on the raving aortic aneurisms and meningitis cases, then we will be able to really come forward as a profession rather than navel gazing and fighting each other, and it will achieve nothing. (Taunton)

Limitations

The percentages related to responses in the questionnaires should be treated with great caution as some respondents indicated a supportive and/or positive response by ticking the 'yes' box(es) but then gave a very critical or negative response in their free text response, others indicated in their free text that they had ticked yes or no to the question they thought they should have been asked rather than the one actually asked and so on.

The themes evident in the questionnaire responses are also evident in the comments made at the regional events and there is certainly some overlap between the questionnaire respondents and those who attended the regional events. Some respondents clearly waited until after they had attended a regional event before they completed their questionnaires because they mention this in their response.

Debates are necessarily set up to offer opposing perspectives. The polarised views expressed in the debate may therefore have had an impact on the nature and presentation of the written responses received as well as the analysis of the questions and points raised during the debates themselves.

Common themes across all data sets

Despite the limitations outlined above, the common themes across all data sets were that although many in the profession could see that defining a scope of practice might highlight what is special and unique about osteopathy and had the potential to bring greater understanding to the public, patients, and other healthcare professionals about what osteopathic practices and osteopathy have to offer it might not be feasible and could have negative consequences too. Questions about feasibility related broadly to concerns about the activity of defining being intrinsically reductionist and therefore its lack of congruence with the holistic philosophy of the profession. The negative consequences suggested were that having a defined scope could potentially restrict innovation in and development of the profession as well as change case mix and impact on indemnity insurance etc. There was particular opposition to the three categories proposed in the consultation document. There appeared to be less resistance to defining a scope of practice if it was focused on principles rather than treatments and was consciously inclusive and embraced all parts of the profession.

Overall there was a request for much more consultation about both the desirability and feasibility of developing such a framework.

Issues for further consideration and conclusions

To conclude fewer than half of those responding to this consultation supported the notion of defining a scope of practice for osteopathy in the format proposed. There was particular antipathy to the three categories proposed. There would appear to be a strong need for further consultation and development work with the profession. This work is likely to need to convince more than half the profession that defining a scope of practice is a worthwhile exercise; working out a way of managing the tension between an inclusive and holistic approach based on principles and the regulatory and safety need for clear identification of appropriate interventions; it may also be useful to give consideration to clarification of what osteopathy is not as well as what it is.

Appendix 1: Osteopathic Practice Framework

Consultation questions

Name (optional)

Registration Number (if osteopath – optional)

Organisation (if appropriate)

Please provide your responses and comments below or submit online through the GOsC's public and o zone websites: www.osteopathy.org.uk.

1. a) Do you feel that there is a need to define the scope of osteopathic practice?

Yes [] **No** []

b) If your answer to (1a) is yes, what benefits do you think defining the scope of practice would bring?

c) What disadvantages do you see arising from a defined scope of practice?

2. a) The Osteopathic Practice Framework document sent to you is the GOsC's initial attempt to set out a scope of practice. In your view, is the overall approach taken in this document appropriate to define the scope of osteopathic practice?

Yes [] **No** []

b) If your answer to question (2a) above is no, what alternative overall approach would you propose?

3. a) On pages 7-11 of the Framework document, the GOsC has attempted to divide osteopathic practice into three broad categories, i.e. typically encountered, less typically encountered and least encountered. Do you agree with this form of categorisation?

Yes [] No []

b) If the answer to question (3a) above is no, what alternative categorisation would you suggest?

c) Do you agree that the types of practice included in each category reflect the reality of osteopathic practice?

Yes [] No []

d) If the answer to c) above is no, what alternative grouping in each category would you propose?

e) What elements would you add and/or remove from each section?

4. Do you have any further comments you would like to make?