General Osteopathic Council Seminar on Values, Standards and Osteopathic Care

12 November 2014

Introduction

1. In 2011 and 2012 the General Osteopathic Council (GOsC) commissioned Professor Della Freeth of Queen Mary University to explore factors affecting the preparedness to practise research of osteopathic graduates. Amongst other things, the research showed strong themes of diversity and isolation.

2. Recent research (2012 to date), in conjunction with Sue Roff, shows a range of views about the seriousness of lapses in professionalism or breaches of standards. The research shows that there are varying perspectives about seriousness of lapses in professional behaviours and appropriate actions to take. The research suggests that there may be factors other than professional standards which influence the way that professional's view behaviour.

3. This theme – that there may be factors other than standards which influence the way that professionals view professional behaviours and the ways in which professional actually behave - is also emerging in research commissioned specifically a team led by Professor Gerry McGivern of Warwick University (2013 to 2015). This research was commissioned to address:

    - What regulatory activities best support osteopaths to be able to deliver care and to practice in accordance with the Osteopathic Practice Standards (OPS)?

    - What factors inhibit osteopaths from practising in accordance with OPS?

    - What factors encourage osteopaths to practice in accordance with OPS?

4. The research shows (inter alia) that compliance with standards is less likely if the standards are not fully understood or perceived as irrelevant to every day practice.

5. Discussions with osteopathic stakeholders have shown that there is a need to better understand and make explicit, patient and clinician values and their interaction as part the development of education and standards.

6. These findings and views, taken together with the importance of person centred care, the culture change as recognised in the Francis and the Berwick reviews, along with the independent and sometimes isolated nature of osteopathic practice has led us to the view that further discussion about the explicit values underpinning the interpretation of standards is important as we consider our forthcoming review of the *Osteopathic Practice Standards*, the core standards for registered osteopaths.

7. A seminar took place on 12 November 2014, comprising patients, the public, students, osteopaths, representatives from other professions and regulators to explore these ideas and the implications for development of professional standards.

8. This paper provides an outline of the seminar findings and explores next steps.

Session 1 – Introduction – Harry Cayton

1. Harry Cayton, Chief Executive of the Professional Standards Authority chaired the discussions throughout the day. He introduced the day for participants. The outcomes for the day were to:

    - To understand the context that osteopathy is practised within.
    - To understand how values come into osteopathic health care.
    - To explore, debate and discuss professional values in osteopathy through case studies, exercises and other formats.
    - To consider the relationship of values to professional standards and practice.
    - To explore next steps.

2. He said:

The seminar today was exploring professional development in an area where there is work to do across the piece and particularly where people are not constrained by the formality and control of the health service. Values and commitment to quality are important in osteopathic care because there is no extended contact such as is the case in the NHS. This is an important theme for all health professionals it is about how professional people do good things and how they avoid bad things.

Professor Malcolm Sparrow, a Professor at Harvard University and expert in regulation across a range of sectors, talks about the role of the regulator in preventing harm as well as promoting good and the balance that the regulator has to find in those roles.

MacMillan Cancer Support developed values based standards which reflected both the needs of professionals and which tried to bring out the patient voice.

The conundrum of the regulator is that no matter how hard they try to engage with professionals to develop standards, professionals say that the standards don't bear any relation to how they work. The standards need to be translated into practice and values.

Professor Bill Fulford and Professor Stephen Tyreman will lead an exploration of these ideas. The seminar today is not about telling people what to think but helping people to explore these ideas through discussion.

Session 2 – Setting the scene: osteopathy – context and patient perceptions – Tim Walker and Brigid Tucker

3. Tim Walker and Brigid Tucker began by setting the scene about osteopathy and osteopathic regulation and patient perceptions.

4. The outcome for this session was:

    - To set the scene for the seminar today. To describe osteopathy, the context within which it is practised, the challenges and benefits from the perspective of a regulator, how we got to the seminar today.

- To share patient perceptions and perspectives about osteopathic care today.

5. Tim Walker began by describing osteopathy, osteopathic regulation and the thinking leading to the seminar today. Tim said:

   One of the principal functions of any regulator is to set the standards of conduct and competence for the profession for which they are responsible. In the case of the General Osteopathic Council we have a duty to produce a Standard of Proficiency and a Code of Practice that are brought together in our Osteopathic Practice Standards.

   When I attend meetings with osteopaths around the country, one of the things we sometimes discuss is how these standards have evolved: where did they come from, how have they developed and whether they are relevant to osteopathic practice?

   These are all important questions if our standards – now and in the future – are going to be an effective tool for maintaining and enhancing the quality of patient care by osteopaths.

   So what, if any, are the answers?

   If we go back in time to the GOsC's predecessor as a regulator, the voluntary body called the General Council and Register of Osteopaths, their standards were much simpler.

   The first clause – and I quote from the 1950 version – stated that 'Members shall at all times conduct themselves in an honourable manner in their relations with their patients and the public and with other Members of the Register'.

   Clauses two to seven were all concerned with restrictions on the advertising of services.

   The final clause allowed for removal from the Register for violation of the Code of Ethics, improper conduct in the exercise of his profession or conducting their private life in a way that caused 'grave and public scandal'.

   Over the intervening years, and with the establishment of statutory regulation some fifteen years ago, I hope we have made a little progress.

   Our current Osteopathic Practice Standards, which came into force in September 2012, consist of 37 separate standards and associated guidance across four separate themes: communication and patient partnership; knowledge, skills and performance; safety and quality in practice; and professionalism.

   I won't go into the process that we went through to develop these standards, but there are many drivers for why changes are made and standards evolve. These can include: evolving best practice across professions; changing public attitudes; and significant external events.

For example, in the latter case, all of the regulators are currently considering changes to their standards and guidance in the light of the Francis Report to see if they adequately reflect the duty of individuals to be candid with their patients when things go wrong.

Harry's organisation – the Professional Standards Authority – also challenges us as regulators to demonstrate, among other things, that our standards reflect up-to-date practice and legislation, prioritise patients, and take account of an appropriate range of views in their development.

But we all know as regulators that the existence of standards alone is not enough. As regulators we risk taking a view of standards which is driven largely by the evidence we obtain from when they are breached, i.e. when we receive a complaint, rather than whether and how they are applied in day-to-day practice by clinicians.

So my view is that we need to have a much clearer understanding of what motivates and drives the behaviour of the many – and indeed the role of our standards in relation to this – rather than simply identifying the transgressions of the few.

So I hope that what we can explore in some detail to today is less about what osteopaths should or shouldn't be doing, and more about why particular behaviours are important for safe and effective patient-centred care.

To frame this discussion more clearly, we need to think a little more about what we know about osteopaths, osteopathic education and osteopathic practice.

First of all, for the benefit of those in the room with a limited understanding of osteopathy, and with apologies to the rest, here is a snapshot of the profession in the UK.

Osteopathy is a form of healthcare diagnosis and treatment that is manually-based, working with the structure and function of the body, to restore and promote health.

There are about 4,500 osteopaths working in the UK at present, the majority, approximately 90%, working in the private sector rather than the NHS. And indeed with many of these individuals working as sole practitioners, often in their own homes.

While it is a small profession, it has a reasonably high level of public recognition (if not understanding). Our research shows very high levels of patient satisfaction – sometimes as high as 96% – and we also know that as much as three-quarters of patient referrals come through personal word-of-mouth recommendation.

The training and practice of osteopathy has evolved in recent years and continues to do so. We have gone from a position where taught courses in

osteopathy are less akin to an apprenticeship model to a more academically rigorous approach, where the majority of new registrants are now educated to Masters degree level with a far greater focus on evidence-informed practice.

As well as this diversity of educational backgrounds present in the profession, there are variety of treatment modalities which are informed by different interpretations and applications of osteopathic philosophy.

Combined with the lack of a defined scope of practice, osteopathy must be viewed as a very broad church.

So the approach that we take in the setting of effective standards means that these must be able to 'speak to' the profession in a way that deals with this heterogeneity.

This situation is reinforced by a paucity of unifying professional support structures – I have already referred to the fact that nearly half of all osteopaths practise alone – but even those who work with others often do not do so in a formal employment arrangement, and rarely in a clinical team as would be found in many other healthcare professions.

Historically, the profession has had weak professional institutions, although to their credit the Institute of Osteopathy has now embarked on the journey towards being a fully-fledged chartered professional body.

One of the traditional hallmarks of the osteopathic approach has been the idea of the patient as a whole functioning unit, and 'holistic' approach which is now widely accepted across healthcare professions. However, this osteopathic 'person-centred' rather than 'condition or disease-centred' approach may not be completely analogous to the more widely understood concept of patient-centred care based on shared decision-making between patient and practitioner.

So where is all this going and why is it important to us as a regulator to explore these issues in more depth?

I think that this can be encapsulated in three things:

First, over the next year or so, we will embark on the revision of the Osteopathic Practice Standards. In preparation for that, we need to consider whether we want to undertake a general editorial update or a more fundamental bottom-up review.

Second, over the past few years through research in a number of areas – on patient expectations, on preparedness to practise, on professionalism and on continuing fitness to practise – we have gained a far greater understanding of how the osteopathic profession practises. We have also been undertaking a study that will be published later this year on the effectiveness of regulation and what is most likely to encourage adherence to our standards. All of this knowledge must be used to inform our standards revision.

Third, if our standards are to have impact, they need to have a clearer underpinning narrative of not just the do's and don'ts but the whys I referred to earlier. To me this is why this seminar on values is important, because it may be that through this we can find an approach that works more effectively for patients, for osteopaths and, dare I say it, for us, the regulator.

Session 2 (continued) – Setting the scene: osteopathy – patient perceptions – Brigid Tucker

6. Brigid Tucker focussed in patient perceptions.

7. Brigid said:

I feel slightly alarmed to be talking about patient views and wary of telling a room full of patients and people who spend day with patients what patients think! This is about what patients tell us when we ask them through research. We are constantly seeking opportunities to tap into views, experiences and concerns of the public. We couldn't achieve anything meaningful as a regulator without knowing this.

We tap in to some of those views using our own patient and public partnership working group – they help us check their thinking and also by undertaking independent commissioned research.

The University of Brighton undertook some research to help us to understand expectations of patient care. 96% of respondents told them that they were very satisfied with patient care.

More recently, we have also undertaken a series of patient and public focus groups across the UK where patients and the public talked about their perceptions of care and osteopathy particularly.

This presentation is a summary of those views. We will also be testing those views further through a national survey which will help us to test how widely held these views are.

Themes from the research included:

- Trust is bedrock of practitioner / patient relationship. Trust - what is it – it's a feeling a package – it's hard to sum up. Patients said they think 'am I happy with this person?' If no, - one is not comfortable, one walks away and perhaps decides to see another person instead.

Research showed that three things were linked to trust in health professionals

- Professionalism
- Strong regulation and
- Links to health service itself.

What do people mean by professionalism? They mention factors such as chemistry, the way the osteopath looks, their bedside manner, competence with which they practise and the expertise that comes across from the health professional.

We compared public perceptions of osteopaths' to their perceptions of other health professions. On the one side are GPs who are highly trusted. At the lower end Chinese Herbalists and osteopaths somewhere in the middle.

Talking to people with no experience of osteopathy, we often heard of their doubts about efficacy and doubts about the professional standing of osteopaths. They didn't know how well osteopaths trained and they were a bit sceptical saying things such as 'my spine is important to me' and 'do they do more harm than good?'

However, people who had experienced osteopathy spoke very highly of it and were advocates. Their responses fitted with the previous commissioned research showing 96% levels of satisfaction. Although even this group did mention a sense of variability/ People often said that they had tried numerous osteopaths before they found the right one for them.

We asked people about the triggers to see an osteopath:

- Recommendation
- GP referral
- Friends and family – more than 70% of patients are word of mouth.
- Desperation and speed of access

Patients reported some concern about the issue of desperation. They said that they will do anything suggested because they just want someone to turn off the pain. Only afterwards do they realise that they didn't think very hard about how they selected.

What are barriers to entrusting care to an osteopath?

There was lots of talk about lack of awareness about what osteopaths offer and do. People often used the word fear and anxiety about what would happen. Public described this as a 'fear of the unknown'.

The fact that osteopathy is not part of the wider health service is a concern. People had a sense or perception that services provided by the NHS are tried and tested: somehow legitimate. If osteopathy is not available on the NHS they feel a little bit more like guinea pigs: that it is untested.

The holistic philosophy of osteopathy does not appeal to everyone. Some found this too 'airy fairy'. On a more pragmatic basis there were some concerns about cost and affordability – exploitation and unnecessary treatment.

What do people tell us are most important to them?

There are four or five basic things:

1. They want to get better and they want to get better as soon as possible: they want their normal life back.
2. They want to be in control of themselves again – individual agency
3. They want to understand their problem and honesty about what can be achieved.
4. They want to trust their practitioner – their competence and expertise.

It is important for the practitioner to manage those patient expectations.

Patients want:

- To be treated with respect and listened to.
- Practitioners to properly understand their story – to take a full clinical history.
- The practitioner's undivided attention.
- To observe professional behaviour – clear professional boundaries and respecting confidentiality

Amongst the complex fabric of education, training and competence these are crucial expectations and preferences and concerns to be explicitly weaved through.

Moving forward into the morning there are some fundamental questions that emerge from patient views and expectations to be pondered throughout the day. These are:

- How well aligned are professional standards and values aligned with patient expectations?
- How well do the Osteopathic Practice Standards meet patient expectations?

Session 3 – What are values and how do they come into osteopathic care? - Professor Bill Fulford and Professor Stephen Tyreman

8. The desired outcomes for this session were for the group to explore what values are and how and why they are an integral part of practice.

9. Professor Bill Fulford introduced the session explaining that the group together would be working on developing values and exploring what values are through an interactive exercise.

Exercise 1 – What are values?

10. Participants were asked to describe three words that described values for them, write them down and discuss them with a neighbour.

11. The group were then asked to feed back in a plenary session going round each of the tables, until all the values that they had discussed were captured. The

feedback from group participants is outlined at Table 1 below. (See also flip charts for Ex. 1 at Annex B.)

Table 1 – What are values

Value	**Number of times mentioned**
Behaviour	3
Judge / how we judge	2
Beliefs	3
Trust	2
Principles and ethics (intrinsic)	2
Quality (meaning)	1
Communication	1
Professionalism	2
Doing good	1
Motivation	2
Doing it right	2
Identity	1
Reflection	2
What we care about	1
Moral compass	1
What feels right	1
Honesty	2
Confidentiality	1
Attitudes	1
Integrity	1
Compassion	1
World view	1
Reliability	1
Commitment	1
Code of conduct / standards	2
Intrinsic	1
Culture	1

Complexity

12. Bill Fulford facilitated the feedback and noted that the learning point from the discussion was that there was great diversity in the top three values of individual participants in the group. He noted that values are more complex than something we normally think about. He noted that a lot of the concepts that we use are quite difficult to define and this is why we often turn to the discipline of philosophy to help us to understand these. He noted that medicine and osteopathy were both complex areas and the difficulty of defining these disciplines was equally challenging!

13. Bill set the challenge – 'how do we manage standards in this highly complex and diverse environment?'

Shared

14. However, Bill also noted that the words chosen by participants were not completely random. He noted that there were some overlaps in the list.

15. Bill asked the group to consider whether they completely disagreed with anyone else's values?

16. The group discussion included:

    - Most people appeared to agree with most of the values outlined by others.
    - Another noted that the words described by the group included two sets of words. One set appeared to be words that we might struggle to use to describe values as an entity. The second set appeared to be words which are actual values. He also noted that he found the entity of the word difficult and couldn't find single words but had to write phrases.
    - One member felt uneasy about judgement – he liked what feels right to him as an individual. Control from an outside agency did not feel right for this individual. This brought out a helpful discussion about the tension between what an individual may consider to be right and what the regulator may consider to be right. This was described as the 'iron cage' of regulation. Others commented that in nursing practice, people find a way around 'school rules' if they don't make sense to them.

17. Bill Fulford reflected on the comments and suggested that

    - Diversity – values are highly diverse
    - But values for a part of 'evidence based medicine'.

18. Bill went on to discuss 'evidence base' as the best research evidence provided one understands that that means qualitative as well as quantitative. Bill explored Sackett's view of evidence based medicine. Sackett said that the evidence base on its own is not enough: the evidence base needs to be combined with clinical experience, tacit knowledge and skills as well as values. This means patient values – what are values – concerns and expectations – integrated into clinical decisions to serve the patient.

19. Sackett said that when the best evidence, patient values and clinical experience are properly aligned, clinicians and patients form a diagnostic and therapeutic alliance which optimises clinical outcomes and quality of care.

20. The conclusions from this exercise were that although values are highly diverse, they are an integral part of providing good quality care.

Exercise 2 – What makes a good osteopath?

21. Stephen Tyreman introduced the next exercise which was about participants exploring values in osteopathic health care. Participants were invited to put one word each onto 3 post it notes to describe a good osteopath and participants discussed this with their neighbours – but were asked not to change anything that they had written once the discussion started. The participants were also asked to identify themselves as a patient (P), an osteopath (O) or everyone else (E).

22. The groups again fed back in a plenary session their words for describing a good osteopath or good osteopathic care. Table 2 describes the words fed back in this session. (See also ex 2 flip charts at Annex C).

Table 2 – Describing a good osteopath / good osteopathic care

Value	**Number of times mentioned**
Care/empathy/compassionate	Several times
reflective	1
Helps patient/efficacy/effective	2
Skills/techniques/expertise/ knowledge/experience	Several times
Professionalism	3
Communication skills	3
Safe (not harmed)	2
Learning	1
Business like	1
Open	1
Humble	1
Wider awareness – outward looking – not osteo centric	1
Helps colleagues	1
Altruistic	1
Honest	2
Complies with current standards	1
Belief in what the osteopath is doing	1
Professional integrity – techniques doing	1
Competence	1
Patient centric	1
Confident	1
Open – wide awareness	1

23. Bill Fulford and Stephen Tyreman facilitated the discussion in this session. He noted that this also was a diverse list but asked participants whether they noted anything that was not the mark of a good osteopath.

24. The discussion included the following:

- The tension of a business like practitioner and a clinical encounter was highlighted. Some noted that even in the NHS there is a need to be 'business like' in the sense of being clean and on time. What does altruism mean in the osteopathic context?
- The word 'humble' was discussed by the group and the group wondered if this was a word that was seen in other professional groups. It was felt that humble in the context of not being arrogant and being aware of the limits of ones competence was helpful.

25. The learning point for this session was that the diversity in values remained. But when considering good osteopathic care, three were more overlaps in the words used than when considering values in the abstract sense. However, the complexity of values remains even in the context of good osteopathic care.

Exercise 3 – 'Kill or cure'

26. The aim of the next exercise was to explore how values and evidence might link up in the context of osteopathic care.

27. The aim of this exercise was to make a decision in a clinical scenario where there was a clear and certain evidence base. Differences in view about options would therefore be based on values. The scenario was that the participant has an illness. There were two evidence based treatments. Treatment 1 was a 50 / 50% chance of instant cure or instant death. Treatment 2 provided a fixed period of remission but then the individual would die from the illness. The question was – how long would the remission need to be in order for an individual to select treatment 2 over treatment 1 and why.

Table 3 – Period of remission required to choose Treatment 2 over Treatment 1

No of years of remission required to choose treatment 2 over treatment 1	**No of people**
O to 2 years	5
2 to 10 years	8
10 to 20 years	7
20 plus years	5

28. In discussion, it became clear that participant's life circumstances (family, dreams) played a part in their decision. See flip charts at ex 3 (Annex D).

29. This exercise showed that even with the same evidence base, decisions made can be different depending on an individual's circumstances and values. The right decision in any circumstance depends on both the evidence base and the values of the individual. Values link science and knowledge to real people and real lives. This is the basis of person-centred care. Bill noted a nuance in that values played a part both from the perspective of the patient but also the practitioner.

30. The conclusion of this exercise was that values + evidence = person centred care.

Summary

31. The summary of this session and the learning points identified by the group in this exercise were:

    a. Values are complex
    b. Values can be shared
    c. Values and evidence = person centred care.

32. Bill and Stephen outlined the suggestion of a values tool kit to help map our way through the complexity and conflict of values. The tool kit could draw upon ethics, regulation and law to help us to navigate what feels right and what is imposed on us.

33. GMC Cartoon – 'GMC delivers good value by striking off 10 times more doctors this year…' Value – getting rid of poor practitioners or contribution to good quality care? The cartoon highlighted a clear divergence in values!

34. Bill asked 'how can we find ways of encouraging positive practice?' They explained that there have been a range of ways on other areas to explore this including medical humanities, decision tree analysis (e.g. statins), health economics, evidence based practice. He explained that the area that we are focussing on today is about values based practice – there has been comparatively little in this area – but it is based on how we can make decisions using a framework of shared values – built around clinical stories – the main story is about low back pain.

35. Bill explained how he had developed values based practice in the context of the Mental Health Act – using the law to provide medical treatment to people against their wishes. Key values were critical in applying the law properly and included:

    - Use the law only for the purpose intended
    - Respect
    - Involve the person concerned as far as possible
    - Use the least restrictive alternative

36. The values were translated into a code of practice and training materials to support the implementation of values based practice.

37. The challenges in implementing were about promoting good practice versus risk driven practice and this managed to lose the proper implementation of values based practice. Indeed perhaps this posed a question about the impact of the environment on values.

38. But the ideas are similar, and there is an opportunity to develop this thinking further in the context of osteopathy.

39. The group then discussed their deliberations so far:

- What are values? – It was difficult to define these high level concepts – they are often defined by how we use them in practice and context.
- Risk and poor practice – safety – is 'safe' always putting your patient first? Patients do want to be safe – but they also want to get better. Are values ever paramount? This was an interesting point and Bill used the analogy of the Lord of the rings – when one value is treated as paramount – it is often to the detriment of the situation because by its nature, if one value is treated as paramount, others are not given sufficient weight in the particular context.
- What does safety mean in the osteopathic context?
- The framework is the law. Codes of practice provide enable us to make explicit and define values.

Session 4 - Developing common themes – interactive exercise – Group work

40. Fiona Browne introduced this session and invited group members to put together their post its describing good osteopathic care and to explore the development of common themes.

41. Most groups were able to complete the task connecting and theming their post its.

Table 4 - themed post its – (see also ex 4 themes post its at Annex E)

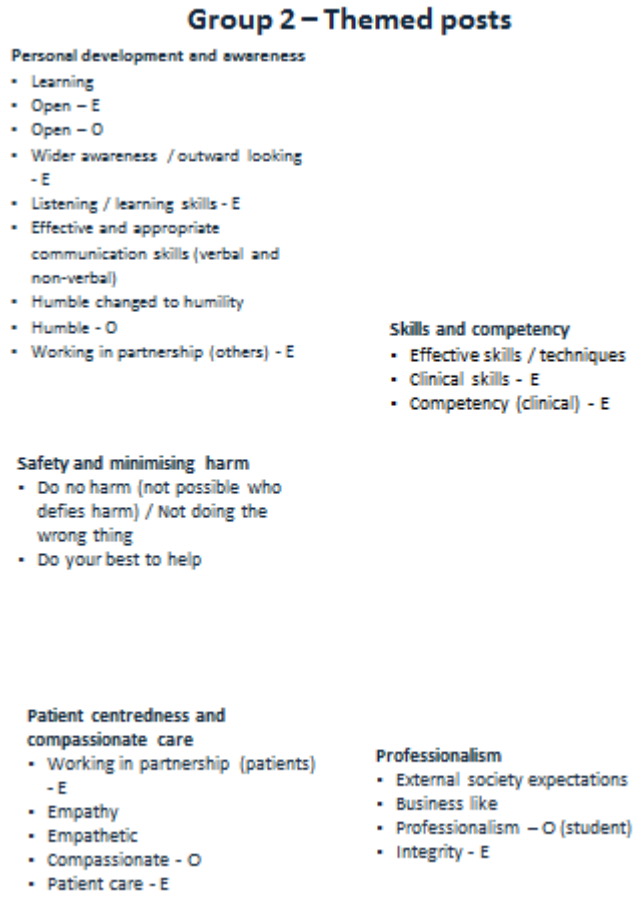
Group 1 – Themed posts

Effective patient interventions
- ? Expertise (knowledge and experience) - ?
- Knowledgeable - E
- Clinically sound - E
- Effective - O
- Integrity i.e. treatment plan - E
- Competent at treatment - E
- Patient centred - P
- Efficacy - P
- Accuracy of outcome - P
- Identifying and improving condition - P

Professionalism
- Compliance with current standards - ?
- Professional - ?
- Professionalism – O
- Professionalism – P
- Confidence in their ability – P
- Professional - ?
- Integrity - ?

Personal values and professional behaviours
- Communication Interaction in identifying needs (lacking) – P
- Good listener (some evidence) – E
- Clear communication of management plan – E
- Trustworthy – E
- Reflective – O
- Honesty - ?
- Confident but how humility / willingness to learn - ?

Integrity
- Regarding choices / charges
- Record keeping
- Confidentiality
- CPD / keeping current
- Working within competence



42. In feeding back this group felt that there were five domains as illustrated above. However, they noted that there were some cross overs between the different domains too.

Group 3 – Themed posts

What you feel
- Compassionate - O
- Empathy – O
- Care – O
- Caring – P/E
- Empathic / empathy – P
- Empathy – E
- Belief
- Integrity – E
- Integrity - O

What you do
- Patient – knowledgeable / experienced
- Competent – P/E
- Skill – O
- Skill (clinical listening) – O
- Competence – O
- Knowledge – O
- Good diagnostic / clinical skills – E
- Proficient / skilled – P
- Skill – O
- Competence – skills

How you behave
- Continuous improvement – reflection and awareness – E
- Communication – O
- Good communication skills – E
- Communication – O
- Professional – P/E
- Professionalism - O

Group 4 – Themed posts

Theme 1
- Care and empathy for the patient – O
- Caring – O
- Caring – E
- Empathy – O
- Patient centre – E
- Compassionate - ?

VALUES

Theme 2
- Safe
- Does no harm – O
- Safe – E

Theme 3
- Effective
- Competent – O
- Skilled – E
- Makes patients better – O
- Skilled - ?
- Helps patient – O
- Diverse practical skills – O (student)
- Do your best to help

EFFECTIVE

INFORMATION AND CONSENT

Theme 4
- Good communication
- Good communication skills – O
- Professional – O
- Honest

PROFESSIONALISM

Theme 5
- Helps develop other osteopathy and health professionals – O
- Altruistic
- Reflective – O
- Professional - E

COLLEGIALITY

43. In the feedback session, the groups fed back on their flip charts at Table 4 above and made the following points:

- Entry to practice and degree
- Target driven – private sector
- Minimum competence to practice
- Evidence based practitioners – practitioners who are safe and competent

- Personal development and self-awareness
- Patient centered and compassionate care
- Professionalism
- Organisation

- What is a value – the circumstances within which they occur

- Is the patient safe to treat?
- Can I treat the patient safely?
- Safety and effectiveness – what is in the middle

- Personal development and self awareness
- Compassionate care
- Skills and competency
- Safety/no harm
- Professionalism
- Working in partnership
- Humble and humility

44. Another group noted:

- Collegiality and professionalism – professionals to work together to support and challenge practice
- Connected – patient centredness – caring and connected values supported by effective and skilled practice and information, conversation and communications
- Central themes were:
    - Professionalism – integrity, choices, record keeping, confidentiality, CPD, working with others/Professional values/Effective intervention
    - Collegiality – traits and values/risk taking/irrationality
    - Personal autonomy and personal agency – although it was noted that collegiality and autonomy were not necessarily opposites and that both could be appropriate in their own way.
    - Patient perspective – efficacy and risk management/professional body of opinion/knowing when to ask for help / autonomy – baseline performance and risk taking within profession.

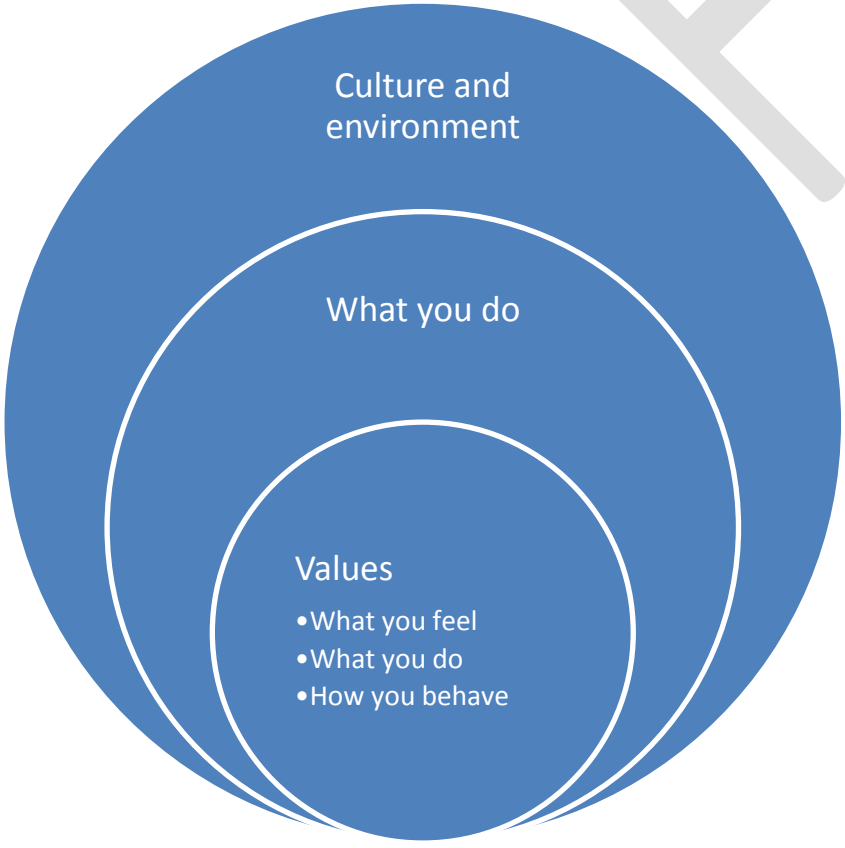
45. Stephen noted that sometimes values were working together and sometimes there was a tension in all the frameworks identified. But even where tensions are identified, it was still possible to find a way through – in other words tensions did not mean opposite ends of the scale. The participants agreed –

personal autonomy and agency, for example, was not a problem, providing one knew where to stop – or the limits of competence – when it was appropriate and necessary to get in touch with others. So knowing when to stop was a value judgement too.

46. An additional value was identified through the discussion– a strong sense of autonomy – can confuse non-osteopaths and patients. Strong body of professional opinion.

47. Another group fed back their discussions. The themes that they had identified included:

    - What you feel – care and empathy – is this an innate quality or can it be learned? If this can be learned – how do we manage that?
    - What you do – skill, competence and development
    - How you behave – communication
    - Belief and integrity – integrity – acting in accordance with your own values.
    - The table below (table 5) illustrated how they saw their framework fitting in to the environment within which osteopathy is practised.



48. The group discussed the relationship between the patient perspective and the professional perspective and the extent to which they matched – difference. We had the benefit of direct Mid Staff experience and explored the learning from

mid Staffs where the structure in place had found to be wanting, for example, leadership and their absence in osteopathy.

49. The group discussed evidence based practice and how important this is to patients and the extent to which it directs the practitioner. Can these skills be taught and how are they assessed / can they be assessed?

50. The group agreed that culture and environment developed a complexity within the theme. But that the complexity or the tension was not the same within al situations. What was needed were the skills to balance the tensions in other contexts. The regulator needed to facilitate this process. Does this framework reflect the wider population?

51. At the end of this session the group were developing a shared framework which allowed the tension to be more explicit and understood.

Session 5 – Case studies – Joan and Josh

52. Stephen Tyreman introduced this session. He noted that in the in the previous session we found that we do not always share the same values. We make different choices for a range of reasons that ultimately have to do with what we each consider makes a good human life. Despite the differences we were able to identify common themes – points of agreement and he set out the instructions for this session.

53. The groups were asked to explore the case studies exploring whether there is poor communication and potential or actual conflict or tension. These case studies are reproduced at annex F.

54. The groups were asked to consider the following questions:

- Is it a problem of understanding or of knowing the best thing to do?
- Is the dispute about facts, values or perhaps both?
- What would be 'good care' in each of these situations?
- Are there different perspectives on this?
- Are there also shared values?
- Does everyone (the people in the story and your group) agree on what is good?
- What is the measure of 'good'?

55. The groups were asked to try not to resort to blaming behaviour according to set standards. Instead, please do try to get beneath the 'correct' response to identify what makes the correct response correct, if it is indeed correct.

56. Next, the each of the four groups was allocated a particular area in relation to standards and to consider the implications of the case studies for each areas of practice as follows:

- Undergraduate education (including recruitment)
- Standards and continuing fitness to practise
- Person-centred care
- Clinical management decisions.

Discussion in individual groups included:

57. Tensions were illustrated through the patient's understanding of what the osteopath does and the patient understanding of their own capabilities. In relation to Joan:
    - One patient was lost – had a fear of falling – how could we gain her trust? The osteopath wants to get her better but the patient is frightened of falling again.
    - What is her support network? – We need to look at the whole person including their support network.
    - Wanting to help is a shared value. Osteopath felt that they knew the best way forward, but it was important for them to step back, if something didn't work in this situation, work around it.
    - Stepping back – what does the osteopath think? What is good practice?
    - The cases illustrate a back of the mind concern but without putting your hands on the patient, it is difficult to know.

58. In relation to Josh Webster, the group discussed the following:

    - His lumber spine was too mobile – this is why he gets hypertonic (tight) muscles.
    - Therefore the treatment that he wants is not relevant and will make it worse.
    - What do to keep him happy – massage?
    - Exchange of money makes it more difficult.
    - What is the job – to fix a problem or to optimise function?
    - What want – what are expectations? Honesty / partnership?
    - No shared decision making here – a disconnect.
    - Shared values around getting better.
    - Practitioner values versus patient values.

59. The groups fed back in plenary session (see also Ex 5 flip chart at Annex G).

60. Initial responses to Joan and Josh showed that there were heated views and differences of opinion generated by both of these cases. Discussion included:

    - Patient values
    - Practitioner values
    - Heated views and emotional responses
    - Complex
    - Multi-faceted issues
    - Different perspectives

- Different views of what 'good' is.

61. The groups were asked to consider why there was passion and emotion?

- Different belief structures
- Differing opinions
- What is healthcare for osteopaths? What is our place in healthcare?
- The diagnosis was wrong
- Society
- People matter and so the debate gets heated
- Professional identify
- Different views about what is ethical and how to marry patient expectations and ethics.

62. The groups fed back about the implications for each of the different areas that they were asked to consider.

Undergraduate education (including recruitment)

63. The group considering this topic fed back the following for consideration in developing standards for undergraduate education (including recruitment)

- There were different views about what might be wrong with Joan and also how she should be treated with some feeling that Joan should be treated (and possibly referred) and some feeling that Joan should not be treated by an osteopath at all).
- The case of Josh was interesting because it brought into direct conflict what the patient wanted and the right treatment for him. It was felt that to continue to treat him in the way that he had been treated was not good for his health.
- Views can change and so admissions shouldn't use values to recruit to. (Doesn't take account of education).
- Issues arising from the scenario included communication
- Consent – Can Joan consent?
- Boundaries
- Duty of care
- Who is responsible for Joan's overall management
- Exercises and ethics and philosophy to deconstruct the scenario and rebuild
- OEIs are businesses recruiting students (same tension as arises in delivery of independent healthcare?)
- Individual v professional values (not corporate v NHS values and policies)

Standards and continuing fitness to practise (CPD)

64. The group considering this topic fed back the following for consideration in developing standards and CPD.

- Challenge is that standards are framed positively, yet fitness to practise – how practitioners are judged against them is negative.

- Debate about whether to treat or not – knowledge, skills and values.
- Care, empathy, skill – we could tick them off against all of these.
- Patient had a poor outcome and Josh would be grumpy without treatment.
- Communication could be improved – perhaps CPD needed here.
- Empathy didn't work (although the practitioner was caring) – the patient relationship broke down.
- Josh – should the osteopath treat? Tension with patient choice and practitioner integrity
- Is osteopath treating a patient in pain v something more?

Person centred care

65. The group considering this topic fed back the following for consideration in developing person centred care:

    - We found the practitioner lacking – not safe or effective – insufficient and not meeting the *Osteopathic Practice Standards* in this context.
    - Practitioner decided that their view was most important and they were not open.
    - Resources may affect values – we found a difference between the independent sector and NHS values in our group
    - In terms of person centred – we used patient centred as opposed to practitioner centred or practitioner led care.
    - Person centred v condition centred = different values
    - Health professionals – needed to rule out cancer first before health professional in community care

Clinical management decisions

66. The group considering this topic fed back the following for consideration in developing clinical management decisions:

    - In considering clinical management decisions, this group looked beyond the patient to the environment and the social context. Solutions were non-osteopathic.
    - A clearer dialogue was needed with options, benefits and disbenefits.

Session 7 – Summary and next steps – Harry Cayton

67. Harry Cayton said a few words to summarise his impression of the day. He highlighted the Professional Standards Authority view about right touch regulation. He said

    Regulation creates a framework within which professionalism flourishes. Regulation should underpin, support and reflect the professionalism that the profession itself defines.

    One of the themes noted throughout the day has been complexity and diversity. We started off with diverse views about what values are. Then, at the end of the

morning session, when we began to theme values in the context of a good osteopath, we felt that we had a framework that we could begin to use.

But when we came to using the case studies, we realised that it was still extremely complex and showed us how difficult values are to put into practice. This was an extremely important lesson for the day.

In considering each of the steps, the case studies helped us to put values into practice.

One participant noted that the value of analytical tools were as a framework to guide thinking – but that it was one lens and that other lenses were important too.

Professional identity as an osteopath was an important value – and the extent to which professionals identify as osteopaths is something to unpack.

Honest tradesmen (like me!) do not have a defined body of knowledge that they have to have and so we do not have the same kind of identity as osteopaths.

Identity was something that we saw strongly in the medical profession. Doctors wanted to pay a fee just to stay on the medical register even when they had stopped practising.

There were differing views – the Carnegie Foundation – students are clear about professional identify but others took the views that professional identity grows with a professional. What would a General Human Being Council look like dealing with moral failures!

Today we explored values trumping technical skill. But we learned that we shouldn't allow one set of values to have preference over another – but how to we reconcile conflicting and interlocking values. With data protection – there is not right answer about what is in the public interest, and so we needed a Committee to help to make a decision. How can we tell the difference and make decisions between two rights? For example, in the case study – we are right when treatment is not necessary and right getting the patient better.

Values and interest in ethics – how to resolve the conflicts of the good including:

- Standards of the profession
- Patient safety
- Public interest
- Public confidence

Today has set the group on the beginning of a journey (argument?!) – carried out with intelligence, good humour and professionalism.

Next steps

68. The group agreed to participate in the next steps which were to:

a. Write a report
b. Consolidate the findings from today and begin to map a journey to the start of the review of the *Osteopathic Practice Standards*.

Annex A

List of seminar attendees

Attendees

Mary Agnew – General Medical Council
Steven Bettles – European School of Osteopathy
Douglas Bilton – Professional Standards Authority
Fiona Browne – GOsC Head of Professional Standards
Stephen Castleton – Oxford Brookes University
Harry Cayton – Professional Standards Authority *(Chair)*
Maurice Cheng – Institute of Osteopathy
Sarah Spencer Chapman – Swansea University
Sarah Eldred – GOsC Communications Manager
Alexandra Freeman – Osteopathic student (London School of Osteopathy)
Professor Bill Fulford – University of Oxford – St Catherine's College *(Speaker)*
Sally Gosling – Chartered Society of Physiotherapists
Don Grocott – Private Patients' Forum
Michael Guthrie – Health and Care Professions Council
Fiona Hamilton – London School of Osteopathy
Pat Hamilton – College of Osteopaths
Jonathan Hearsey – GOsC Council Member & Chair, GOsC Osteopathic Practice Committee
Kit Holmes – GOsC Professional Standards Manager
Charles Hunt – British School of Osteopathy
Hilary Jones – Consultant
Ben Katz – Osteopathic Alliance
Stuart Korth – Osteopathic Alliance
Jan Lander – Patient
Keith Lander – Patient
Professor Gerry McGivern – Warwick Business School
Manoj Mehta – British College of Osteopathic Medicine
Samad Peidaei – Osteopathic student (British School of Osteopathy)
Professor Stephen Tyreman – British School of Osteopathy *(Speaker)*
Brigid Tucker – GOsC Head of Policy and Communications *(Speaker)*
Sue Roff – Consultant
Steve Vogel – Editor, *International Journal of Osteopathic Medicine*
Marcus Walia – Surrey Institute of Osteopathic Medicine
Tim Walker – GOsC Chief Executive and Registrar *(Speaker)*
Alison White – GOsC Chair of Council

Apologies

Apologies were received from
Jagtar Dhanda
Steven Vogel
Sally Gosling