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Final Report of the Consultation Exercise in Relation to Draft Revisions of the General Osteopathic Council's Standards of Practice

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Contents

1 Introduction and acknowledgements

Following acceptance of our proposal to complete this work with the General Osteopathic Council (GOsC) the project began with the initial meeting on Friday 28th May 2010.

The original invitation to tender for the work had stated the aim of the project as being:

'...to provide us (GOsC) with a representative and balanced consultation analysis, through the development of a consultation which elicits responses from our key stakeholders.'

Our proposal outlined our suggested approach for achieving the stated aim and this was discussed and adapted at the initial project meeting, details of the methodology are provided below at section 5.

We would like to thank all members of the GOsC staff who worked with us on this project for giving so generously of their time and expertise. Particular thanks go to Marcus Dye and Kellie Green the GOsC joint project managers for all their guidance, support and unfailing good humour, but most importantly to all those who responded to the consultation process without whom none of this would have been possible.

2 Themes from the findings

When reviewing all feedback received, we have observed a number of themes and these we detail below:

- In general respondents found the 'new' Osteopathic Practice Standards a useful document and felt that combining the two documents (Standard of Proficiency and Code of Practice) was a good idea
- The layout and format of the document was generally liked. Many commented that they really liked the two colours as they felt it added to the clarity of the document. Others commented that the colours used were in fact very similar, this created difficulties when printed off in black and white and also for anyone who is colour blind. A substantial number did feel that it might assist the clarity of the document if the 'standards column' was all shown in a bold typeface
- We were regularly told that this document '*seems like another stick to beat us with'; 'it is another means to hang us'* and '*lawyers will be able to use this against us'.* On many occasions the comment was made '*this is all about the protection of the patient – what about us?'*

  We have commented elsewhere (in more detail) that there does perhaps have to be further promotion/provision of information about the Regulators role and we raise it here as a matter for consideration. We found it very surprising that many osteopaths did not seem to appreciate that in protecting patients this also protected them. We recommend that some actions need to be taken to explain this fully but simply, and for it to be a continuous and on going message
- It was often suggested that case studies/examples/definition were needed. Although we understood and fully appreciated these points our opinion was, and remains, that this document is not the place for such things. However, we do feel that there would be considerable value in making this provision with perhaps the addition of Frequently Asked Questions (which could be a 'live' document). This may of course fall more within the remit of a Professional Body rather than the Regulator

- There was considerable concern expressed in regard to informing patients of the 'risks'. We are not of the understanding that this was because there is disagreement in principle. The concern was related to their opinion that there was insufficient research and data relating to risk and this led them to request prescriptive detail of exactly what should be said to the patient. It is fair to say that some concern was expressed that in giving this information to a patient (when in fact the actual risk is not totally proven and is likely to be miniscule) could create unnecessary fear in the patient, and this in turn might render any treatment less effective
- The issues relating to modesty, covering the patient etc were debated long and hard with a very wide range of views and opinions. Everyone appeared to wish to respect cultural/religious beliefs, but many felt that in order to provide a 'best quality treatment' they did need to see the patient undressed and they found covering them up during treatment a hindrance to this. Others talked about the ridiculousness and cost (initial outlay for suitable covers, ongoing laundry etc) of this, whilst yet others appeared to have no issues with it at all
- The offer/provision/use of chaperones and interpreters also led to considerable debate and variance of interpretation. Many understood what was stated as meaning the osteopath had to make this provision, and they expressed considerable concern about their ability to do this and the cost of doing so. Reference was made several times about the issues particularly for sole practitioners and also home visits. We also had considered the issue (as did some respondents) of the safety of the osteopath in these situations, and what precautions they may need to consider/take
- There was variation in opinion in regard to Fraser Guidelines and Gillick principles. Some feedback stated very clearly that this was not applicable in Scotland, whilst others said it was, and there was uncertainty whether or not it was applicable in Northern Ireland
- There are a number of Guidance points which contain the words 'must' and 'should', this makes the guidance appear to be prescriptive or mandatory and therefore it is no longer guidance. This feedback was received from the vast majority of respondents and usually it was suggested that the word had no place in guidance. The fact that it was there did we felt create confusion on what guidance actually was and how it would be 'used', and also it created concern for these reasons
- The overriding statement in Section A refers to 'absolute' trust. The vast majority of respondents felt that 'absolute trust' was not achievable and this had to be amended
- The numbering of the document goes somewhat awry and this needs correcting. In addition a number of respondents commented that it was sometimes difficult to be absolutely clear which standards the guidance related to
- Consent was another topic which was heavily commented upon. In general respondents felt there was a lack of clarity in what was actually required in regard to written or oral consent, as a one off, at each appointment, for every technique? A large proportion of respondents felt it was unworkable to obtain consent for each technique as this would at best stop the flow of the treatment and at worst be so time consuming that there would actually be very little treatment. It was interesting to note that a good proportion did not see this as an issue and that they talked this through whilst treating. It did appear that those more recently qualified had less of an issue

- Guidance 36.6 caused regular debate. The issue discussed related to the final sentence '*This applies even after they are no longer in your care'* and what exactly did '*should not take advantage of your professional standing'* mean? It was felt that it could be argued if an osteopath met an ex patient in a social setting and said *' Hello, how are you? How is your back now? Can I buy you a drink?'* may be interpreted as taking advantage of professional standing. It was also stated that particularly in rural environments it is almost inevitable that osteopaths will meet their patients in social settings and, this could very easily then lead to a relationship
- There seemed to be differences of opinion as to whether or not a treatment plan has to be written or not and therefore perhaps some greater clarity needs to be brought to this
- Many people commented that Standard D2 and Guidance 2.4 (particularly) seemed to relate to audit. For some this seemed to cause concern, others simply asked that if this is what is meant, it should be clearly stated and detailed requirements need to be provided
- We received considerable feedback on Standard C9. It was almost unanimously felt that it was not possible to keep patients from harm **whatever** the cause
- Standard D15 Guidance 31. Many respondents felt that this statement was either unclear or inappropriate. If it means that there is a requirement to tell the patient what the osteopath's margin on the retail sale (within their practice) of a pillow this seemed inappropriate.

3 Findings

We did at all times during the project assure respondents that their feedback would be reported back anonymously to GOsC. The amount of feedback received has been considerable and very careful consideration has been given to how this should be reported. In order to demonstrate our full appreciation and respect for the time and thought given by respondents we have concluded that we should provide all raw data (completely anonymised and removed from the questionnaires etc) to the GOsC project managers, in order that they can take this to their working group with whom they will be taking this project forward. Within this report we provide details of the findings in a generalised format and also provide some specific quotes from respondents which support the findings, this has of course been reflected in the section above 'Themes from the findings'. We have shown feedback from:

- British Osteopathic Association
- Osteopaths (shown as focus groups, telephone and face to face interviews and questionnaires)
- GOsC fitness to practise committees
- Education Providers (includes Osteopathic Educational Institutions and Osteopathic Education Providers)
- Patient Groups
- Students
- Others (shown as questionnaires).

The numbers responding to the consultation were as follows:

183 individuals attended Focus Group meetings (13 focus group meetings were attended by osteopaths and two were attended by the GOsC fitness to practise committee members, which includes both lay and osteopathic members)

160 responses were received to the electronic questionnaire (8 were from students and 1 was from a patient group)

89 telephone interviews were conducted with osteopaths

and

8 face to face interviews/meetings were held with osteopaths.

As stated above, we ran two focus groups with GOsC's fitness to practise committees and these groups included lay members. Taking this into account, we have shown their feedback separately in this report.

Although the feedback from patients within this project is very limited, the responses from patient representative groups have been included within the findings. We are also fortunate in that, the very recently completed (September 2010) Osteopathic Patient Expectations (OPEn) study, carried out by researchers at the University of Brighton Clinical Centre for Health Professions can inform our findings here. The second phase of that project was a qualitative study which aimed to provide a basis for development of a survey questionnaire. The qualitative data analysis sought to answer the question, "What are the specific aspects of osteopathic practice about which patients have expectations?" This does provide a useful insight into what patients are potentially likely to think about certain aspects of the Osteopathic Practice Standards.

In reporting our findings on the structure and content of the document, we have set out a significant number of key messages from the profession, in the form of requests for clarification, and recommendations on alternative phrasing, which came from the responses to a range of questions about the usage and efficacy of the Standards and Guidance. It should be noted that a very small minority of professional respondents were opposed to the principle of the standards and their place in the regulation of the profession - we hope that we have reflected these concerns sufficiently in the following pages.

3.1 General comments

Over 70% of respondents stated explicitly that the document was an improvement on the previous ones, with comments ranging from *'a fair first draft'* to *'overall an excellent document'*. A number of professional respondents expressed the opinion that they were pleased that GOsC was listening to the profession, in the pursuit of patient and public protection.

Comments which reflect some of the positive feedback we received from the profession include:

'a huge improvement on the previous documents.... helpful for the schools to teach to'.

'Important to protect patients against the few bad practitioners, but so much is commonsense anyway'.

'... not too directive or prescriptive for the experienced practitioner, and sufficient to assist the newly qualified'.

'Good, normal language... Important to be seen to be doing this - shows the level of aspiration for the profession'.

'I was initially concerned about how it would be achieved, but very pleasantly surprised with how it has come out'.

'...a good document; it sets the boundaries for interaction between osteopath and patient'.

'Very good to be doing this - a valid approach. Conciseness is spot-on - enough guidance on osteopathic consultation balanced with how to run your business. Might have helped to have some of this drip-fed into the last year of training'.

'It does its job: the document could have been much bigger, given the task in hand, so its current size is to be welcomed...'.

'Straightforward and comprehensive'.

'Clear and easy to read'.

'..in general seems good...'.

'(We) consider this a much better document than the previous two; though would like to have an additional document which is "chattier" than the Guidance. This would be particularly helpful for Section D, as good examples could be provided in that type of document'.

From British Osteopathic Association (BOA):

'Our overview is that the document is generally acceptable and well constructed... Our main area of concern revolves around regulatory creep an example of this is standard D17 point 40.2 concerning civil proceedings.'

3.2 Combining the Code of Practice and Standard of Proficiency

In general respondents found the 'new' Osteopathic Practice Standards a useful document and felt that combining the two documents (Standard of Proficiency and Code of Practice) was a good idea.

From the questionnaires and focus groups, 97% agreed with the proposal, with the remainder of respondents expressing the need for further guidance on the primary target audience and how GOsC expects the Standards to be used.

The overwhelming majority of the individuals interviewed from Osteopathic Educational Institutions and Osteopathic Post Graduate Training Education Providers agreed that it was a good idea to combine the two documents and they liked the format and layout.

Comments included:

'It relates two areas together, as two documents they can appear unrelated. This document makes the practitioner think of the two together which they should.'

' Very positive move and long overdue'.

Other stakeholders were broadly in agreement with the proposal to publish the two documents together, although particular reservations were expressed by one of the GOsC fitness to practise committees. They commented:

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

In general terms however the two GOsC fitness to practise committees agreed that combining the two documents was a good idea.

3.3 Format of the document

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

The Osteopathic Educational Institutions liked the format and layout.

100% of the focus group attendees commented on the fact that the numbering of the document goes somewhat awry and this needs correcting. In addition, the vast majority of those attending focus groups said that it was sometimes difficult to be absolutely clear which standards the guidance related to, and this comment was also made by many of those who completed telephone interviews.

The BOA considered the document to be generally acceptable. When we met with some of their representatives they suggested that it would be potentially useful to have the Standards shown in a bold typeface because they felt there was a need to ensure the Standards were totally clear.

Students responding to the consultation were positive about the format and layout saying that the things particularly liked about the document were:

'The clear unambiguous writing style'

'There is minimal repetition to that which would occur in two publications'

and

'It is very easy to overview, nicely divided and the colours make it easy to navigate your way through'.

There were some differing views between the two GOsC fitness to practise committees and between individual members of them.

The following comments give an illustration:

'There is perhaps too much detail for patients, perhaps the document can be split so that there is a part for patients and a part for osteopaths.'

'Bringing together the CoP and SoP together in one document is supported... The committee does not support, however, the integration of the CoP and SoP within each of those themes...'

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

3.4 Standards and Guidance

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

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

'...there are gaps in the guidance where more detail would be beneficial. However, it is not clear whether it would be practical to include more detailed guidance within the document without making the document too cumbersome and that it may be preferable to develop separate more detailed issue specific guidance documents where appropriate. There are some areas where the guidance is possibly at risk of taking on the role of a 'training manual' rather than core guidance and others where not enough guidance is provided but this may be where having separate more detailed guidance documents would be beneficial to complement the core guidance provided within the main document'.

There were really very few 'criticisms' or amendments requested by the Osteopathic Educational Institutions and Osteopathic Postgraduate Education Training Providers. With the vast majority being very positive about it.

The following comments are typical:

'I should say that I do not agree with minimum standards, we should always try to rise to a higher standard, shouldn't drop to the lowest common denominator, however I am not suggesting this document does that.'

'This is a big improvement on previous documents.'

'Very carefully worded and fair and inclusive'.

100% of the respondents said that to meet all of the standards whilst working 'pitchside' would not be possible, although we did not get a large amount of feedback (to our knowledge there were actually only two respondents involved in this area).

3.5 Section A – Communication and patient partnership

Around a third of comments made by osteopaths during telephone interviews and from online responses addressed the specific issue of the guidance on gaining consent. The majority of concerns expressed can be summarised as follows:

- Clarification of the need for oral or written consent: some practitioners were concerned about how oral consent could be proven if a case was brought against them. Others suggested that it would be helpful to have a template produced for recording consent and further guidance on how to meet 'minimum standards' in this and other areas. Some respondents felt that there was repetition and ambiguity in some of this guidance, and that it could be reduced somewhat – for instance A2 Guidance 6 and A4 Guidance 17 were potentially contradictory, in that the former requires only oral consent but the latter requires written consent

- A more prevalent concern was about the disruption to the flow of treatment which would be caused by continual seeking and gaining of consent to a range of techniques/procedures that might be used in any one appointment. It was thought impracticable to follow the guidance to the letter - some patients would find it irritating, and others might become anxious about why they were being asked for their consent. However, many respondents remarked that it was normal for them to be talking through the techniques and updating the patients throughout the treatment, without seeking formal consent, and this was what their patients expected.
  Our observation is that the more recently graduated respondents did not appear to have issues with seeking oral consent as they completed the treatment. The impression we obtained from them was this was the way they had been trained

- The references to the Fraser and Gillick guidelines caused confusion to some respondents; these are not universally recognised throughout the UK, and overall it was thought that the guidance on protection of children and vulnerable adults needed greater clarification

- The definition of valid ("specific and informed") consent as set out in the Guidance was questioned. Again it was felt that it would be unrealistic to expect that all patients could be fully "informed" in the time available at an appointment. A number requested clarification on the legal position regarding this aspect

- Osteopaths expressed a range of concerns about explaining risks of treatment to patients e.g. how to quantify risks in the absence of substantive research – a number of osteopaths also stated that one of the distinctions of osteopathy was that it is not an 'evidence based medicine'. It was suggested by some that the wording be changed to 'any risks' and that managing patient expectations would be important in this respect i.e. in explaining the choice of techniques that will help patients and likely short term reactions to treatments.

The following specific quotes give an indication of comments received:

'treatment is organic.... sometimes as many as 20 different techniques in a treatment'

'osteopathy is not procedural, but a response to the body's needs...'

'it is not always helpful to separate consent from treatment...'

'what if the patient changes their mind, even after giving written consent?'

Many other comments on Section A made by osteopaths during telephone interviews face to face meetings and online responses related to the wider issue, communication, in respect of the guidance on treatment of intimate areas and the trust within the patient/osteopath relationship:

- It was felt that the use of the term 'absolute trust' in the introduction to Section A was not appropriate, and impossible to achieve. It was suggested that this (at best) could only be an aspiration or an ideal, although *'ethical behaviour .... should be an absolute demand on us as osteopaths'*. Another comment was '... *how un-osteopathic this statement is - we work together - osteopathy is not paternalistic'.*

- Almost all respondents who commented on the treatment of intimate areas expressed concern about the requirement to explain and then reschedule treatments for vaginal or rectal procedures; not only was this often impracticable for the patient, and would incur an extra cost, it might also create unnecessary anxiety in the patient. Many suggested that this be amended to 'should offer to reschedule..., or should consider rescheduling...' A few made the point that the guidance suggested that these were common treatments, which may not be the case. A number of respondents also felt that the list of intimate areas should be exhaustive, for the avoidance of any misunderstanding

- There was general agreement that the patient's own role in the therapeutic relationship should be emphasised more in Standards A5 and A6, in terms of communicating their symptoms/concerns, development of mutual trust and in following the guidance offered by their osteopath.

Other points made by osteopaths included a range of views on the relationship with GPs; many respondents wished that this could be improved, but recognised that there is a lack of understanding of osteopathy, and that patients themselves were seeking help because other treatment had failed them. Others commented that it might be helpful to encourage patients to report successful treatment to their GP.

Feedback from Focus Groups:

Participants' views from the focus groups reflected the full range of comments received in the questionnaires and telephone interviews, as reported above, and in many cases

suggested alternative phrasing for their areas of concern. The vast majority of the groups commented particularly on the issue of 'absolute' trust, and on the patient's own responsibility to participate in the therapeutic relationship and the area relating to risks.

It was made very clear that in their opinion using the term 'absolute trust' in the opening statement to Section A was inappropriate and we show below some of the comments made:

'...the word absolute in this opening statement be changed to mutual'

'... therapeutically earn trust gradually – it is not immediate'

'...absolute trust is not possible, just trust is sufficient'.

Almost all attendees at the focus groups expressed reservations about Guidance 8.3 in Section A. This very largely related to their opinion that there was insufficient research available to really be able to fully inform patients of the risks and the comments below elaborate on this concern:

'It should state "significant risks". There is very little solid evidence on the actual risks of many treatments, and the GOsC should ensure that osteopaths are made aware of any that have significant risks...'

'The risks need to be a prescriptive list of what they are, to ensure all osteopaths say the same thing.'

'...the risks is too woolly should change to - Inform the patient of likely side effects and significant risks ...'

The issue of 'consent' was raised at all the focus groups with a variety of concerns being expressed. The focus group attendees reflected the opinions of osteopaths during telephone interviewees, face to face meetings and in online responses. This included substantial comment on the need to obtain 'ongoing consent', how you could really be sure that a patient had fully understood and also some issues relating to differences in legislation in the four nations. The following comments are examples of the feedback:

'...Can't get consent for each specific procedure. GOsC should investigate and supply us with guidance on IMPLIED CONSENT what is legal what is practical etc.'

*'At this time there is not sufficient research data to allow a patient to give an informed decision. It can't be said that a patient **must** have an understanding...'*

'A4 Guidance 12,13,14 – Taken at the most literal level this would mean we need to stop, explain technique about to be used and area to be worked on, this will delay treatment. However, accept that there is a need to explain fully initially and talk through as treating. It is concerning in regard to what the legal interpretation of 'informed consent' and 'specific and distinct consent every time' actually is...'

*'How can you really be **SURE** that a patient has understood?'*

'In Scotland the age (when it is presumed a young person can give consent) is 12. Fraser Guidelines and Gillik principles are not applicable in Scotland...'

It is fair to say that at some of the focus groups attended by osteopaths there was some very strong feeling in regard to the guidance on the examination and treatment of intimate areas. Our interpretation of this was that to a degree some osteopaths feel vulnerable because of the issue that each individual may have specific and different opinions on what they consider an 'intimate' area to be. There were also very strong opinions given (by some members of some groups) that it was not appropriate to schedule vaginal or rectal examinations to another appointment, the following two quotes from feedback received, we feel reflects these viewpoints:

A2 Guidance 7 - *'Where has this come from?*' It was questioned by some *'... if patient comes specifically for this – why is there a need for another appointment?*' Some of the group stated *'... giving the patient time to consider internal treatment is good, it builds trust and is safer for everyone.'* Some found it too prescriptive.

'Need absolute clarity on the subject of intimate areas. (Consider in the light of insurer's information.) Mouth should be removed.'

It is also worth stating that a number of osteopaths at the focus groups queried exactly what was meant by Guidance point 5. They were particularly asking this question in relation to osteopaths working in sole practices (often without a receptionist) and also those who worked from their own homes. Their concerns were focused on how a patient would interpret this statement. Again the following statement reflects the feedback received:

'A sole practitioner without a receptionist is likely to need to take calls – patient may read into this guidance that they should not do that...'

Feedback from Patients' groups:

A2 and D7: it was recommended that these sections should include as one of the core standards a reference to openness and honesty in dealing with patients and colleagues, with particular reference to dealing with adverse outcomes and complaints. Quote: *'A complaints procedure will work effectively, if the underlying ethos is one of openness and honesty. The foundation of 'trust' which is referred to within the document is openness and honesty and so this should be recognised as a fundamental attribute of a healthcare professional'.*

The OPEn project findings do assist in informing us of patient expectations in relation to the points covered in Section A of the Osteopathic Practice Standards. We believe the following statements taken from the final report of that project are particularly pertinent:

- Consulting with an osteopath was seen by patients as enabling them to take control of their own condition, to feel empowered through information to help themselves and to feel someone professional was in control of the situation. Patients also expected the planned treatment to be explained in order for them to decide whether to proceed with treatment
- Patients expected to understand, through information given by the osteopath, what their problem was and why it may have occurred. They also needed confidence that the problem would be assessed correctly by an appropriate

person. They expected to develop knowledge of the problem in order to gain some reassurance that the problem could be dealt with

- Patients did expect, however, to be listened to when they were talking about their condition and how it was affecting their body. They also expected to get some understanding of their problem and expected to be able to ask questions of the osteopath in relation to their problem and the defined treatment. Some patients expected to be involved in treatment, for example doing exercises at home, but some patients, were not sure about taking responsibility for their own condition and felt that they should leave this to the osteopath
- Patients expected to be able to trust their osteopath and their decision making processes. They also expected to have treatment risks pointed out to them if there were any. However, many patients did not feel there was much associated risk with their treatments. Patients felt that assurance should be given when treatment was feeling uncomfortable and they expected to have confidence in their practitioner. Some patients did not necessarily expect to give consent for treatment, they felt that attending the clinic in itself implied consent.

Feedback from Osteopathic Educational Institutions and Osteopathic Post Graduate Training Education Providers:

As with the other respondents the issue of 'consent' was regularly commented upon and opinions were divided. The following comments demonstrate this point:

'... what does 'consent' actually mean? This is a minefield. Much is down to trust and the professionalism of the practitioner. This does perhaps need clearer definition'.

'... still some repetition, and over-concentration on some topics (e.g. consent areas). Communication theme could be more comprehensive, to include guidance on different forms of unspoken signals, and also should mention the use of ICT here, as opposed to the Professionalism theme?'

'I think there is potentially an issue regarding consent. I wonder how that part will be interpreted by patients – because everything relies on trust and this document suggests there is no trust. Consent is very important, but much of it is implied. The issue of consent here is too explicit and this is likely to make patients more concerned. The first five minutes with a patient is very important, if there is a break down at this stage, then need to cover consent explicitly, of course intimate areas are different. GPs are not required to obtain consent, so feel this has now rather gone overboard'.

'...the section on consent seems very general. A glossary of terms for this section would be useful or links to other reference documents. I am aware this is a particular area of concern for osteopaths and so I feel more guidance would be particularly useful.'

Feedback from BOA:

This feedback again commented on the section relating to risks. They made a particular point in relation to Standard A3 Guidance 8.3:

'It is important that the findings of the NCOR research into risks is now disseminated so that osteopaths are advised about the risks and how to present them to patients.'

They also (as with other groups) commented on consent, explaining that they considered it almost impossible to comply with a requirement to obtain consent for each and every distinct part of a treatment. They also raised the question how this

related to the patient expectation research completed by GOsC, where patients indicated that by attending and paying for treatment they have given consent.

They added on this point:

' The way the guidance is written needs to be approached from a pragmatic rather than, it seems to us, a purely legal perspective.'

Feedback from students:

Student feedback on this section expressed a requirement for greater clarity and emphasis on the necessity for the osteopath to remain updated and clear regarding the referral pathways for safeguarding children and vulnerable adults.

Feedback from GOsC fitness to practise committees:

There was some debate within one of the groups as to whether or not Standard A1 was actually required, and it was felt that the term 'range and forms' (Guidance 1.1) was unclear and therefore not helpful.

One of the groups stated that Fraser Guidelines (Standard A4) were applicable in Scotland but that a reference footnote was required.

3.6 Section B – Knowledge, skills and performance

Feedback from questionnaires and telephone interviews:

- A small number of respondents commented on the lack of emphasis on osteopathic principles and practice, and the distinctiveness of osteopathy, compared with other manual therapies

- Many more who commented on this Standard expressed concern about the wording of the Guidance, particularly in relation to palpation (B1.1.4), which they felt was under-emphasised as a key feature '*the hallmark'* of the osteopath's range of skills, and how palpatory skills continue to develop, with experience, throughout the practitioner's life. Alternative suggestions were offered, including a comment that the old standard K1 expressed it much better, and another that *'the critical appreciation should be of the value and limitations of palpation rather than its definition'*. However, a small number thought that palpation should be so well understood by osteopaths that it was not necessary to include it in this way

- Respondents commented that descriptions such as 'sufficient', 'adequate' and 'advanced' would need definition, in order to be assessable or measurable in this context. *'Court-proof'* was an expression used by one respondent, and others observed that throughout this section, it would be difficult to demonstrate that the osteopath had acted competently

- The majority of comments on B2 referred to Guidance 2.3, knowledge of human disease sufficient to inform clinical judgement and to enable recognition of disorders not suitable for osteopathic treatment. We were told that osteopaths *'treat patients, not conditions'*, and most of these respondents stated that there

were no patients whose symptoms/condition could not be eased by osteopathic treatment. *'..... fails to recognise that osteopathy in it's breadth is able to treat anybody regardless of their condition. The emphasis implied here is on the condition rather than treating the person - this misses one of the key aspects of being an osteopath'.* Others added that as expressed, this guidance might limit the scope and development of osteopathy, as it could be interpreted as meaning that certain conditions exist that must not be treated.

- B2 2.4 also caused concern for some respondents: for some, the 'degree' of sufficiency needed to be explicit (as mentioned above), if it was to be workable; to a small number of others it highlighted areas of knowledge that had not been covered in their training, thus causing some anxiety about how their proficiency could be measured against this

- In B2 2.5, it was suggested that more clarity was needed in describing the degree of force (or 'level of pressure', as an alternative).

'.... should require understanding of the principles of biomechanics as a whole, not just the effectiveness of the use of force'.

- Both experienced and recently-qualified osteopaths felt that B3 needed further consideration. Whilst the sense of it was broadly understood, the majority felt that it would be impossible for practitioners and practice to develop, if the Standard was followed to the letter. The meaning behind B3 Guidance 4 in particular was questioned. The following comment usefully covers this point:

'..the real issues here are that treatment must be safe and that practitioners must recognise when a patient needs treatment that is beyond their skill and ability to deliver. However, in many cases, the latter is only determined through a trial of treatment conducted with the patient's informed consent'.

- B4 also prompted a number of requests for clarification for example:

'In other professions, Reflective Practice is the norm, and many osteopaths use it as a means of professional development, yet it is not mentioned here as a requirement'

- Guidance 5.2 was questioned, as a potentially unnecessary administrative burden, particularly for sole practitioners, if this is likely to increase record-keeping and data collection. Further discussion and debate was suggested, to evaluate the impact and any benefit to practitioners. The relationship between 5.2 and Standard D2 Guidance 2.4, regarding clinical audit was also raised here

- Almost all respondents asked for clarification or better wording on Guidance 5.3: some wanted to know about relevant/acceptable sources of contemporary advice, with others advocating a role for GOsC in signposting practitioners to this. Most suggested that at the least, the words 'as appropriate' should be inserted in this guidance.

Feedback from Focus Groups:

As with the previous section, attendees at the Focus Groups raised the same range of concerns as those who participated in the electronic and telephone surveys.

It was clear from discussions at the focus groups that there was a considerable amount of confusion as to what Standard B3 and it's related Guidance particularly Guidance 4 actually meant. The following comment was typical:

> *'B3 This appears to stop an osteopath developing.'* It was questioned whether this should say *'If working in area of research...' and also if it actually meant the osteopath should work in research /education. 'What does it actually mean? Currently it is too open to interpretation...'*

Some members of some of the focus groups seemed to interpret Standard B4 as being about 'audit' and if this was correct they really wanted this clarified and many considered that Standard B2 Guidance 2.10 was actually 'self reflection'. The following comments illustrate this:

*'B4 Guidance 5.2 - **If** this is about auditing we must be given an 'audit system tool' by GOsC...'*

'B4 Guidance 5.2 - Is monitoring a core function of osteopaths? It is impractical for small practitioners, and can make an imposition on the patient. The reflective practitioner model is a better way to ensure that quality is maintained. Imposing unrealistic bureaucratic forms of monitoring could undermine the viability of osteopathic businesses'.

'B4 Guidance 5.2 – What is meant by 'monitoring'? If this is actually relating to audit, and audit is to be required then there is a need to first assess the impact of this in practice...'

'B2 Guidance 2.10 – If this is meant to be about self reflection – say so'.

*'Guidance 5.2 **SHOULD** be about reflective practice'.*

We felt that the following comments relating to this section are also worth noting here:

'Opening Statement – Add at end - working within an osteopathic tradition'.

*'B1 Guidance 1.1 This is a very broad piece of guidance. Osteopaths are unlikely to have a knowledge/understanding of **all** principles and concepts'.*

'Too much educational jargon in B1 1.4 and B2 2.10'

'B2 2.9 - suggest changing .. the ability to protect .. to .. the right to protect..'

Feedback from Patients' groups:

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

- *'Working within your competence (B3): this is an issue which is critical to patient safety and therefore one that warrants more detailed guidance'*

- *'Sole practitioners (B4): as with other health care professions, there are inherent risks attached to sole practitioner status in terms of a lack of day to day professional support and peer review by work colleagues. We would recommend that the standards and guidance are amended to take account of the particular issues that arise in sole practice and to safeguard against the type of problems that can arise when a professional is working in relative isolation'.*

The OPEn project findings again can assist in informing us of patient expectations in relation to the points covered in Section B of the Osteopathic Practice Standards. We feel the following statements are particularly useful (note that some statements may be applicable in relation to more than one Section of the document):

- Patients expected osteopaths to have knowledge and skills to reduce pain and to deal with problems affecting joints and muscles. They expected osteopaths to be able to reduce stiffness and soreness and expected a high level of manual skills
- Patients expected more soft tissue massage than manipulation and most patients expected their examination to include a visual examination, and a manual examination followed by manipulation. Patients also expected that treatment would not necessarily work the first time and they expected gentle but firm treatment
- Patients expected osteopaths to recommend other treatments with other health professionals if necessary and to be treated holistically. They also expected osteopaths to be understanding of the range of problems they were facing in their life.

Feedback from Osteopathic Educational Institutions and Osteopathic Post Graduate Training Education Providers:

There was actually little feedback on this section from representatives interviewed. This implies they were in the main content with it. However, we felt the following two comments were worth highlighting:

' No-one speaks about "observation" as a skill/technique (in this document) in the way that palpation is described as a skill, but observation is key, and is taught'.

'Appropriate referral – GPs have often referred the patient to the osteopath, so it is sometimes difficult to know who to refer patient to. This needs to be recognised and made explicit in the document'.

Feedback from BOA:

The BOA feedback supported comments received from others that, Standard B4 Guidance 5.2 needed further clarification as they felt it could (as currently written) be open to interpretation.

Feedback from GOsC fitness to practise committees:

One group questioned whether or not Performance should actually be in Section C of the document

3.7 Section C – Safety and quality in practice

Feedback from questionnaires and telephone interviews:

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

The following quote gives additional comment:

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

- There seemed to be differences of opinion as to whether or not a treatment plan has to be written or not and therefore perhaps some greater clarity needs to be brought to this. In addition, some practitioners were keen to ensure that the nature of patients' responses to treatment was reflected in the guidance on treatment plans - a small number also suggested changing the phrase 'treatment plan' to 'objectives' or 'management plan', in order to acknowledge that sometimes treatment is not required

'*You cannot always make a (treatment) plan and stick to it; the nature of osteopathy is that the treatment and responses evolve. It might be better to replace with objective/s here and elsewhere'.*

- A small number of practitioners commented that in C2, the guidance gave the impression that osteopathic treatment was a set of "justifiable" procedures and techniques, and excluded the need for overall evaluation of the patient, *'i.e. their predisposing or maintaining factors, health beliefs, psychological status etc',* all of which would have a bearing on finding the best course of action for them
- In both Sections B and C, respondents called for GOsC to publish current research, particularly on the safety of specific osteopathic techniques or approaches.
- It was noted by a few respondents that C2 and C3 offered some overlap. In particular, requirement to understand the patient's condition seemed unworkable, and should perhaps include *'do your best to understand...'*

- The comments received on C5 indicated some concern about ambiguity, and the possibility of undermining the practitioner's clinical judgment
- The issues relating to modesty, covering the patient etc were debated long and hard with a very wide range of views and opinions. Everyone appeared to wish to respect cultural/religious beliefs, but many felt that in order to provide a 'best quality treatment' they did need to see the patient undressed and they found covering them up during treatment a hindrance to this. They felt that this guidance worked against the fundamentally holistic nature of osteopathy. Others talked about the ridiculousness and cost (initial outlay for suitable covers, ongoing laundry etc) of this, whilst others appeared to have no issues with it at all, and many commented that patients were also responsible for saying if they were uncomfortable. (This relates to the issues on the patient's role in the therapeutic relationship that were raised in comments on Section A).

The following quote is typical of many comments received:

'a huge amount of information can be gained from watching routine movement, which initially might have nothing to do with what the patient is describing as a complaint'

- The offer/provision/use of chaperones and interpreters also led to considerable debate and variance of interpretation. Many understood what was stated as meaning the osteopath had to make this provision, and they expressed considerable concern about their ability to do this and the cost of doing so. Reference was made several times about the issues particularly for sole practitioners and also home visits, with a number of respondents remarking on the negative aspect of requiring patients to countersign a statement that a chaperone was offered but declined. We also had considered the issue (as did some respondents) of the safety of the osteopath in these situations, and what precautions they may need to consider/take
- Almost all of those who commented on C7 raised concern about Guidance 14.4 - a similar point was made about B3, regarding working within the limits of their competence

For example:

'Whenever we learn a new technique or approach and set out to integrate this into our clinical practice, or when we are developing new techniques and approaches, we are at the edge of our competence, if not beyond it. This standard needs to reflect this ongoing process of development'.

- Some respondents expressed surprise at the length of time that they were expected to retain patient records, and wondered if this was a legal requirement. Others also commented on the arrangements for safe-keeping of patient records after the death of the practitioner; this could cause logistical and legal problems, and perhaps it should be for GOsC to store them
- Feedback received on Standard C9 was almost unanimous in saying it was not possible to keep patients from harm **whatever** the cause, and some respondents asked what the motivation was for introducing this statement: was it about bad practice by other osteopaths, or did it extend to giving advice on health promotion, such as driving safely, alcohol intake, exercise etc.
- A small number of respondents commented on the lack of reference in Section C to cleanliness, standards of hygiene and use of protective clothing/gloves where appropriate. Others asked specifically for guidance on standards required in the case of a pandemic, where clinic staff could be at risk.

Feedback from Focus Groups:

Not really surprisingly, again comments from the Focus groups mirrored those received in the questionnaire and telephone interviews. At some of the groups there was considerable questioning of the use of bold emphasis on particular words in the guidance, which was not consistent with the rest of the document.

A number of the focus groups noted that C6 Guidance 8.2 and 8.3 might be better combined as one point, and that Guidance 8.4 and 8.5 overlap, so just use 8.4, which covers the point sufficiently.

The following quotes demonstrate some of the thoughts coming from the focus group attendees:

C1 Guidance1.3 – *' Training of osteopaths doesn't fully cover all the factors listed. The word recognise should be replaced by be aware of '.*

Standard C2 - *'Guidance 2.2.3.implies that diagnosis is more important than clinical reasoning; change to: be able to demonstrate the reasoning which underpins working diagnosis'.*

C6 Guidance 8.4 - *'Offering means I have to have it and I do not want to have a cover. This is already dealt with in section on respecting patients, also suggest GOsC should consider recent patient expectation research'.*

C6 Guidance 11, 12. - *'This creates a potential risk to the osteopath if couples are trying to set osteopaths up'.*

'...need to ensure that treatment is not directed by patient and this guidance should not be interpreted as ...the patient being allowed to say (e.g. 'just crack my neck', which may be a completely inappropriate treatment'.

C9 Guidance 21 – '*Acting quickly is not always safe: sometimes you need time to reflect. Suggest adding a further point to acknowledge that the best action is sometimes to gather more information.'*

Feedback from Patients' Organisations:

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

'C2: in addition to guidance note 2.8, we would suggest additional guidance on recognising when errors have been made and best practice on how to respond to the needs of the patient'.

From the OPEn project, the following statements are relevant to Section C of the Standards and Guidance *(note that some statements may appear in relation to more than one Section of the document):*

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

- Patients expected the osteopath to have a plan of action with regards to treatment and management. The majority of patients felt that they should have an explanation about possible treatments and treatment choices, and to be involved in this decision making process, but some patients were very happy for osteopaths to take control of their treatment solely
- Some unmet expectations were raised: some patients suggested that they received insufficient preparation for the (forceful) nature of the intervention so that the experience of osteopathic "crunching", and the level of side-effects after treatment, came as a surprise. Some were unhappy about having to undress, or had not realised that it would be required. There was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this is an area of concern for patients where expectations may possibly be unmet. Some participants described previous experiences that had not met their expectations in terms of the environment (lots of cuddly toys in the room) or the relationship/ boundaries (one osteopath described as 'creepy').

Feedback from Osteopathic Educational Institutions and Osteopathic Post Graduate Training Education Providers:

The majority of those interviewed gave no real feedback on this section. However, like other respondents several did comment on Standard C9, saying that this did not really seem possible to achieve.

We felt the following two comments were of particular interest:

Standard C6 – Guidance 8.3 – *'Observing patients undressing. Felt it was strange to put this in. It may be useful for an osteopath to observe this, but not essential. So do not see the need for it to be in the guidance, particularly as the section on modesty really covers it'.*

Standard C8 – Guidance 16 – *'Recording findings – should mention negative findings as well as positive findings'.*

Feedback from BOA:

The feedback from the professional body included a comment relating to Standard C2 Guidance 2.2.2. Interestingly it appeared as a slightly different reasoning from that offered by other respondents, they said:

'This is worrying as it is not clear what is meant by this. Further clarification is needed and a full answer is required in terms of how this might apply as the register is developed over time.'

They also commented that the profession might not question this, as they may not fully understand the possible implication.

The BOA as with many of the other responses commented on Standard C6 Guidance 8.1 – 8.6:

'There is still concern about this and the way osteopaths approach the issue of observation of patients carrying out dressing actions. Our view is that the guidance notes need to work to acknowledge the varying approaches and how they could and should be practiced.'

Feedback from students*:*

As with other groups, some students also commented on Standard C6 and it's related Guidance. The comment below reflects this:

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

Feedback from GOsC fitness to practise committees:

One of the GOsC committees appeared to be understanding of comments received from others in relation to Guidance 8.4. They made the following comment:

'Add in the words... when reasonably practical... after ...parts of the body.'

In addition feedback was provided that suggested that perhaps more information should be given in the Guidance on what comprises a full case history and on the intended scope of a treatment plan.

3.8 Section D – Professionalism

Feedback from electronic questionnaire and telephone interviews:

- It was observed that in this section, some of the Standards and Guidance were not fully aligned, and that the layout should be reviewed, to ensure clarity
- Respondents sought clarification in 1 1.-1.3, and the meaning of 'operational relationships' in 1.4
- 1.5 should read 'appropriate and available' (rather than and/or)
- D2/D3: Concerns were expressed about the likely expense for practitioners to introduce IT systems, and a potential lack of standardisation in this - GOsC should lead on advice and support for practitioners to meet these Standards. Although some respondents felt that IT was being imposed upon them, in spite of their maintaining efficient paper records, others remarked that in line with other professions, osteopathy is fast approaching the time when IT systems will be an essential/integral feature of their practice
- Many people commented that Standard D2 and Guidance 2.4 (particularly) seemed to relate to audit. For some this seemed to cause concern, others simply asked that if this is what is meant, it should be clearly stated and detailed requirements need to be provided, after further discussion across the profession. It was noted that this might even belong as a standard in Section C, as a quality issue
- Most respondents felt that D5 should include exhaustive information, on reasons for declining to continue treating certain patients (5.3), or state more emphatically that the list is not exhaustive. Others felt that the examples did not fit well with the Standard, and some illustrations of what constitutes discrimination would help in meeting the requirements of both D4 and D5

- D6 6.6 and later: The definition of 'valid' consent again caused comment, as in Section A - is consent only valid if obtained in writing? Also some repetition/overlap here on confidentiality and security of information (6.2 and 6.5). The GMC website was quoted as an excellent example of an online tool that could be adapted: www.gmc-uk.org/gmpinaction

- Respondents felt that it would be helpful to have more links to other websites, to access relevant information on standards and legal requirements (e.g. Data Protection, Advertising Standards, Health and Safety, financial records), although a small number suggested that where Standards were part of the (national) legal framework they were superfluous to this document and the statements should be removed

- Most comments on D7 suggested that Guidance12 and 13 should be reworded to lay more emphasis and advice on trying to resolve the complaint locally, before allowing the issue to be escalated to GOsC

- It was noted that not all practitioners belong to a professional association, and this should be reflected in D7 Guidance 13

- Most respondents who commented on D8 questioned the rationale for the guidance on Associates (D8 17), who are normally fully qualified, insured and self-employed, and as such their osteopathy would not be supervised. Clarification was also sought on the definition of junior colleagues - again if they are qualified to practise, they are deemed responsible for their own actions and indemnification

- In D10-D13, Guidance 25, clarification was sought on how to define 'appropriate' and 'adequate'. Some respondents thought this guidance might fit better in Section C (Safety and Quality in Practice), with more specific advice on Health and Safety requirements. There was also thought to be some overlap between D11 and D14 Guidance 27

- D14 and D15 generated a significant response, with requests for clarification on issues of advertising and publicity, financial disclosure including fees for referral; e.g. in Standard D15 Guidance 31, many respondents felt that this statement was either unclear or inappropriate. If it means that there is a requirement to tell the patient what the osteopath's margin on the retail sale (within their practice) of a pillow this seemed inappropriate

- A number of comments were also received, about the encroachment of these Standards (also D16 and D17) upon the practitioner's private life, with some stating that all references to osteopaths' personal lives should be removed from the guidance
- Respondents felt strongly about a number of the guidance statements in D17, and some questioned its clinical relevance. Many felt that D17 Guidance 40 should be re-worded to apply only if the practitioner is found guilty of transgression – *'innocent until proved guilty'* 'was one quote. Others expressed concern that some patients might take advantage of the practitioner's insurance/indemnity by bringing charges for purely financial gain.

Feedback from Focus Groups:

As with other sections, focus groups were in general agreement with the comments made by respondents to the questionnaire and telephone interviews. The following comments and quotations provide additional perspectives from across the groups:

'A list of patients rights should be in this section'

'D3 Guidance 2.1 is welcomed as a replacement for Capability F on IT competence'.

'Should D4 and D5 be combined?'

'D6 - should this specify a time period for keeping confidential information?'

*'D11 - communicable diseases: (*some felt) *more definition and wider coverage needed'.*

'D14 Guidance 28.4 "nuisance publicity" - deemed unclear and unnecessary'.

'D17 Guidance 39 - need to include a phrase about having regard to one's professional standing when not acting as an osteopath; but also to ensure that inappropriate recourse to GOsC is not made when this lies outside the professional work of osteopathy'.

'D17 Guidance 40.1 - should only be for offences that affect ability to promote safe care of patient/s'.

'*D20 specify how to develop effective teaching skills, and criteria to measure effectiveness'.*

Feedback from Patients' Groups:

- (A2 and) D7: we would recommend that this includes as one of the core standards reference to openness and honesty in dealing with patients and colleagues and with particular reference to dealing with adverse outcomes and complaints. A complaints procedure will only work effectively, if the underlying ethos is one of openness and honesty. The foundation of 'trust' which is referred to within the document is openness and honesty and so this should be recognised as a fundamental attribute of a healthcare professional.

Feedback from the OPEn project, the following statements are relevant to Section D of the Standards (and some may also appear in relation in other sections):

- Patients expected osteopaths to recommend other treatments with other health professionals if necessary and to be treated holistically. They also expected osteopaths to be understanding of the range of problems they were facing in their life
- Patients expected a professional approach, particularly with regards to touch which should also be accompanied by appropriate explanation, especially in the situation of a male osteopath treating a female patient. It was expected that osteopaths would behave as professionally as general practitioners and would exhibit exemplary professional behaviour in situations where people may feel vulnerable e.g. in the state of undress. Patients also expected an explanation that states of undress during examination and treatment may be necessary, before arrival at the surgery or on arrival at the surgery

- … There was a discussion of confidentiality comparing GPs' and osteopaths' receptionists, with an implication that this is an area of concern for patients where expectations may possibly be unmet. Some participants described previous experiences that had not met their expectations in terms of the environment (lots of cuddly toys in the room) or the relationship/ boundaries (one osteopath described as 'creepy').

Feedback from Osteopathic Educational Institutions and Osteopathic Post Graduate Training Education Providers:

It was interesting to note that no representatives interviewed from this group expressed any concerns about what others had considered to be the implied use of IT. In fact quite the reverse as the following quote demonstrates:

'Section D6. Paragraph 6 of the Guidance needs to be strengthened in terms of record keeping and its importance. It is not acceptable to keep records in a cardboard box in a corner of the office! Also paragraph 7 needs strengthening with regards to the use of IT. It should be strongly recommended that IT is not an option! Also include appropriate website addresses'.

The following quote also provides a very strong viewpoint, although this was not commented upon in the same way by other members of this group.

'Section D5. The examples in paragraph 5 of the Guidance are too extreme and could be taken in the wrong manner by patients. These examples and this guidance do not fit well with the Standard. There are no examples of what does constitute discrimination and some examples here would be useful'.

Feedback from BOA:

It was this section which appeared to give BOA the most concerns. Many of the points they raised were the same as those received from other groups including:

Standard D14 Guidance 26.7, requesting clarification if this forbids osteopaths to sell goods such as pillows; Guidance 28.4 as they felt this could lead to restraint of trade; Standard D15 Guidance 31, seeking clarification if this would require osteopaths to detail the retail margin of every sale made and D17 Guidance 40.1 when they like many others suggested that this should be re worded to say 'convicted' of a criminal offence.

In addition they made the following points:

Standard D8 Guidance 21.1 – *' We were surprised ... that students in an osteopathic practice (other than a college clinic) might carry out osteopathic examination , treatment or advice. .. can the GOsC detail what it permits as we were of the opinion such an action was not allowed.'*

Standard D14 Guidance 28.1 on which they sought legal advice: *'Our view is that section 28.1 should read as follows: Your advertising is legal, decent, honest and truthful.*

Our rationale for this is that the statement as we rewrite it is adequate. The legal opinion we have is that reference to ASA is not necessary. It may well be that the Regulator may determine that they cannot support an opinion or approach adopted by the ASA (which may be guided by a medical approach to research and evidence that may not be appropriate to osteopathy) but if the practice standards require compliance with the ASA code then the profession would be stymied by this.'

Standard D16 Guidance 36.6 - '*Some individuals have read this as a limitation to normal relationships and this whole section needs detailed reconsideration.'*

Feedback from GOsC fitness to pratise committees:

The GOsC committees as with other respondents provided considerable feedback on Section D of the document. This included a number of suggestions to amend wording in order to provide greater clarity for example:

Standard D6 Guidance 6 – *'Need to specify a time period. Also this needs to take account of legal requirements.'*

and

Standard D7 – *'Change word quickly to timely and suggest put in a timeframe perhaps 15 days, but this needs a clause to cover holidays and sickness'.*

One committee commented that Standard D4 Guidance 3 '*Reference to the views of the registrant might not be the most helpful way of achieving the intention of this guidance. An alternative wording might be – The same quality of service should be provided to all patients regardless of their gender, ethnicity, disability...'*

One of the committees also questioned if in Guidance 40.1 the wording should be 'charged or 'convicted', a point raised by many other respondents.

4 Data

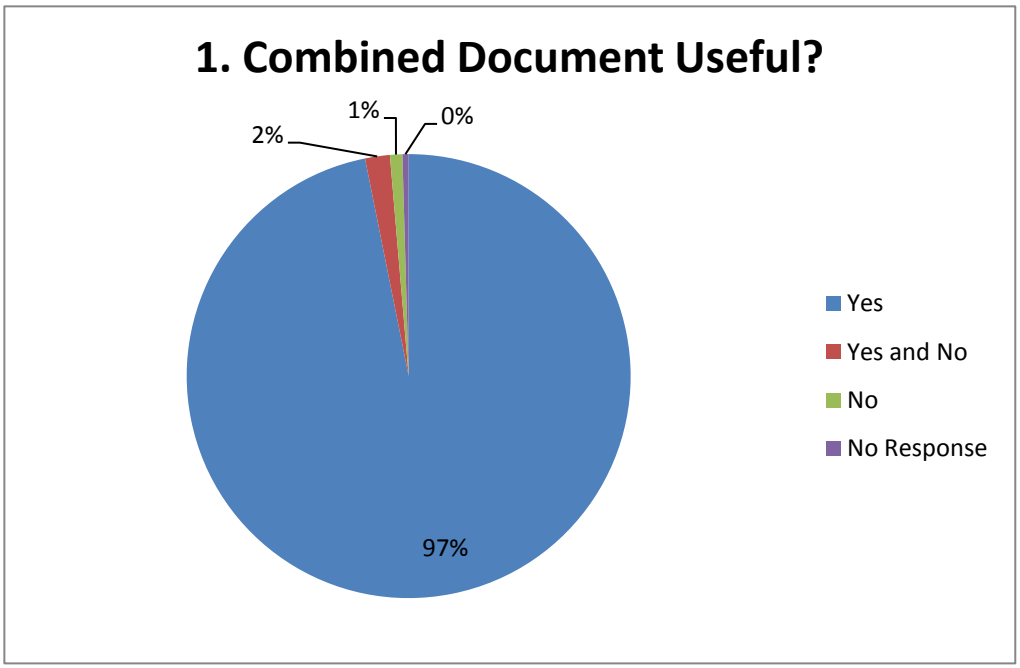
The questionnaires and telephone interviews contained a number of common questions and in this section we show the analysis of these questions.

It should be noted that not all respondents answered all questions and also the nature of the telephone interviews, (semi structured), meant that not all questions were always asked.

4.1 Questions about the format of the document

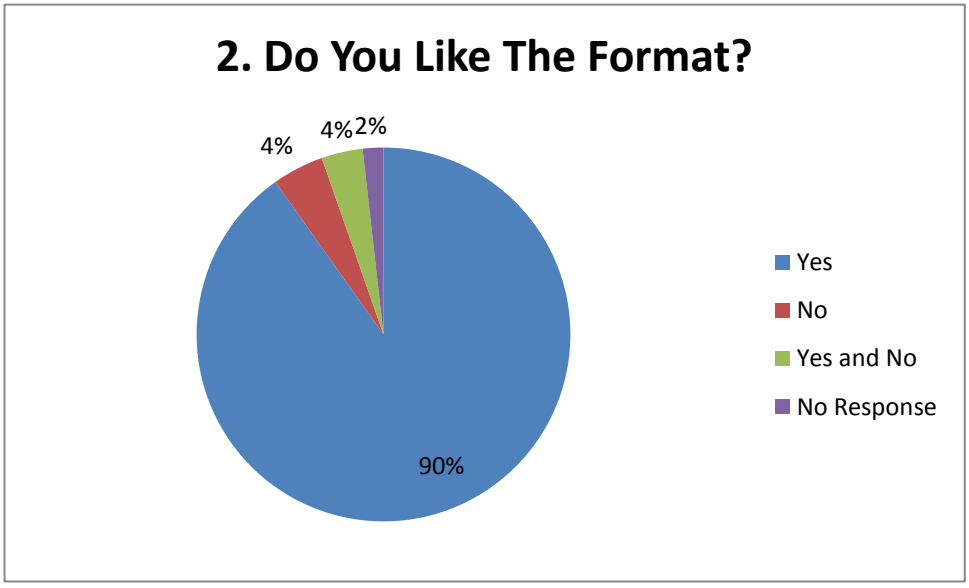
Do you agree that it is useful to have the Standard of Proficiency and the Code of Practise combined into one document?

Yes	215
Yes and No	4
No	2
No Response	1



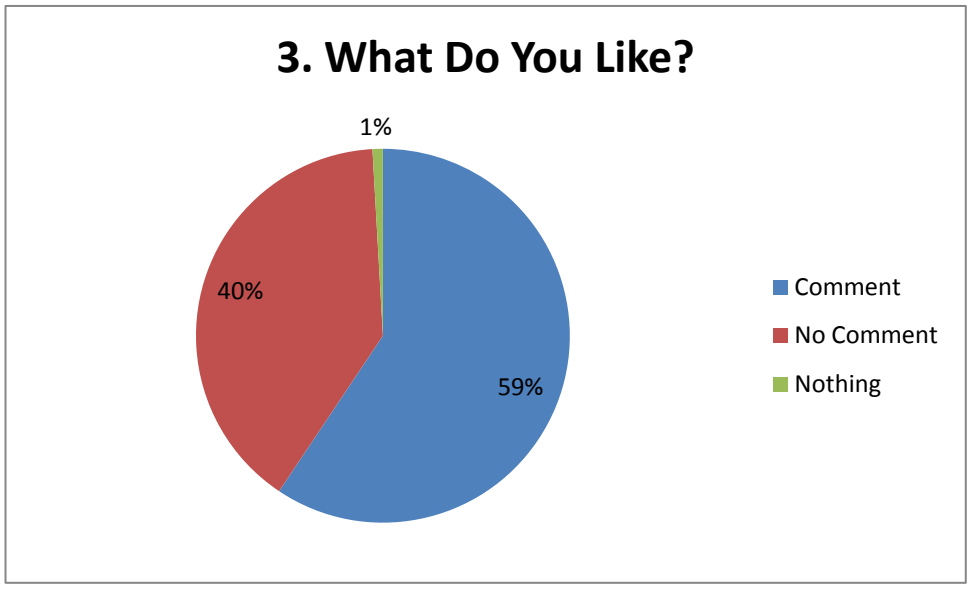
Do you like the format of the Osteopathic Practice Standards document?

Yes	202
No	10
Yes and No	8
No Response	4



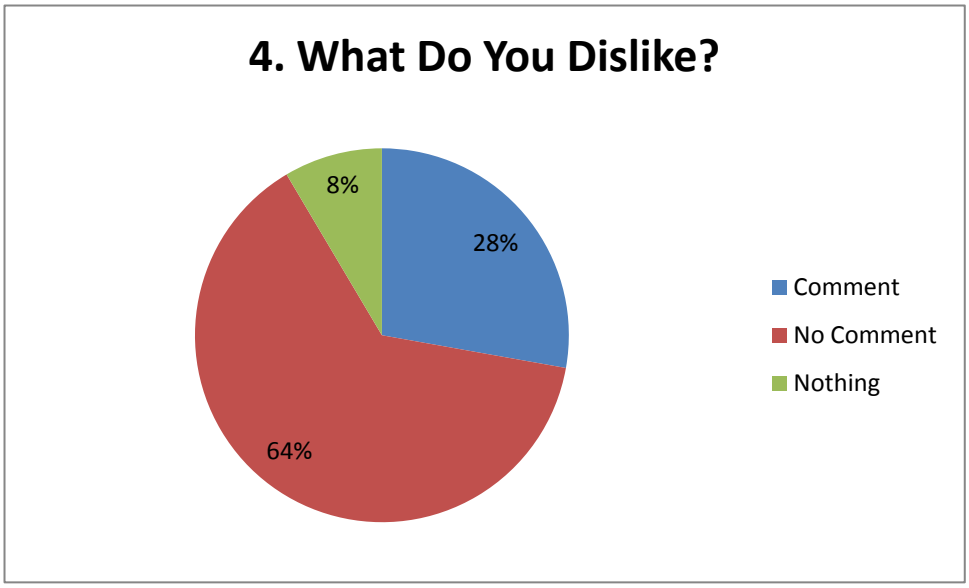
What (if anything) is it that you particularly like about this proposed format?

Comment	133
No Comment	89
Nothing	2



What (if anything) is it that you particularly dislike about this proposed format?

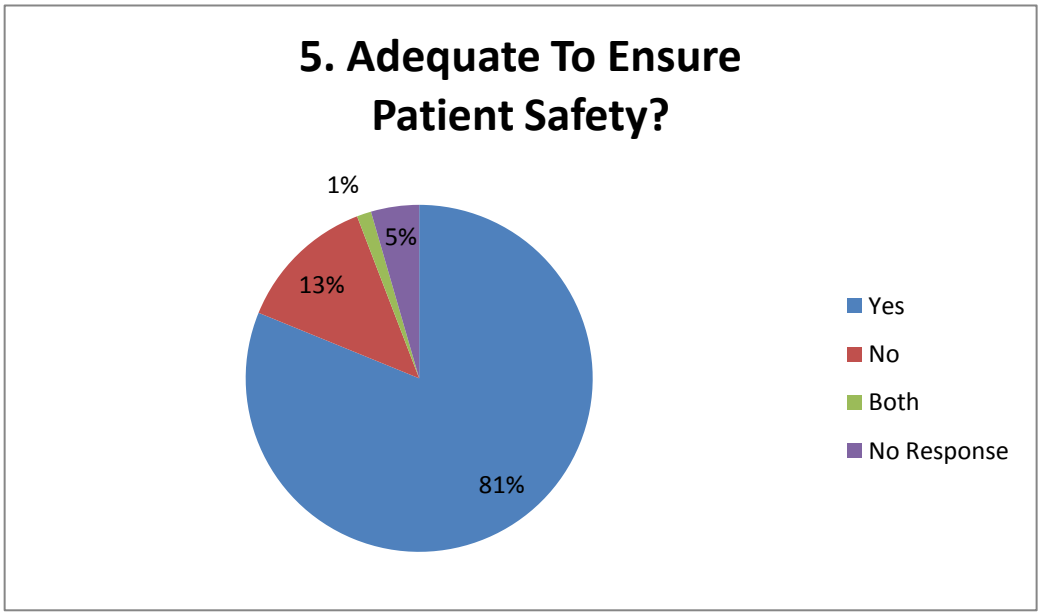
Comment	62
No Comment	142
Nothing	19



4.2 Questions about the Standards

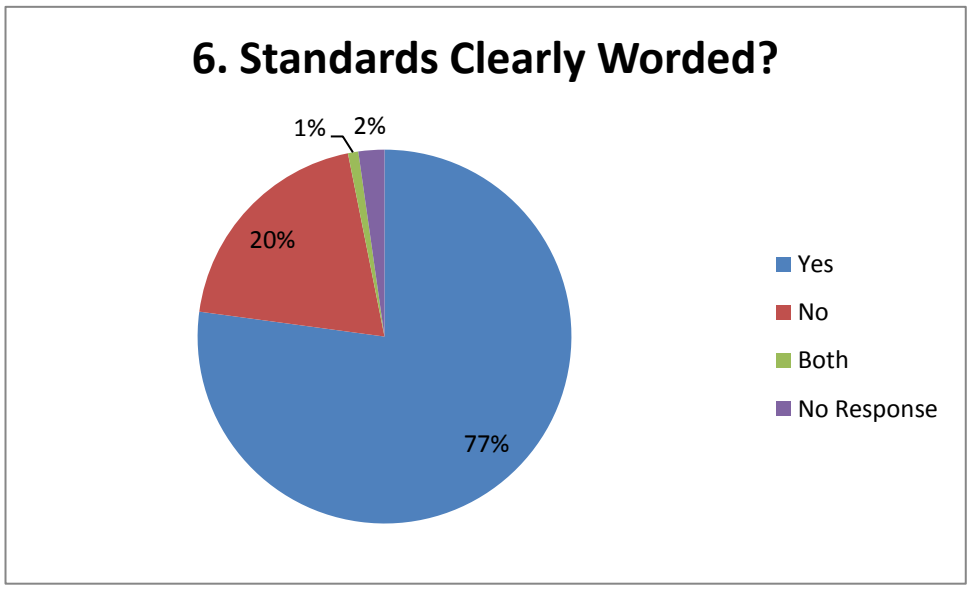
Do you think that the revised standards are adequate to ensure public and patient safety?

Yes	181
No	29
Both	3
No Comment	10



Are the Standards clearly worded?

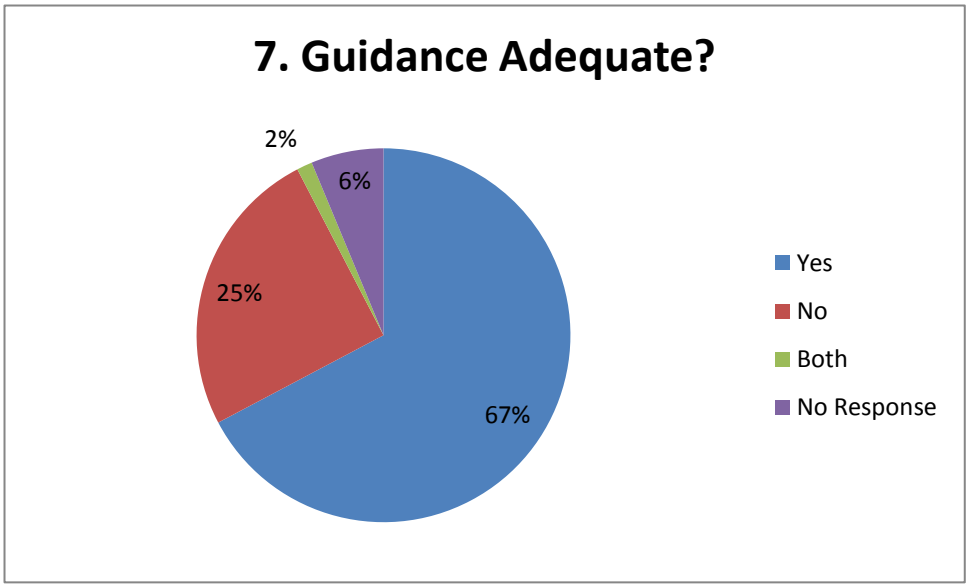
Yes	172
No	44
Both	2
No Response	5



4.3 Questions about the Guidance

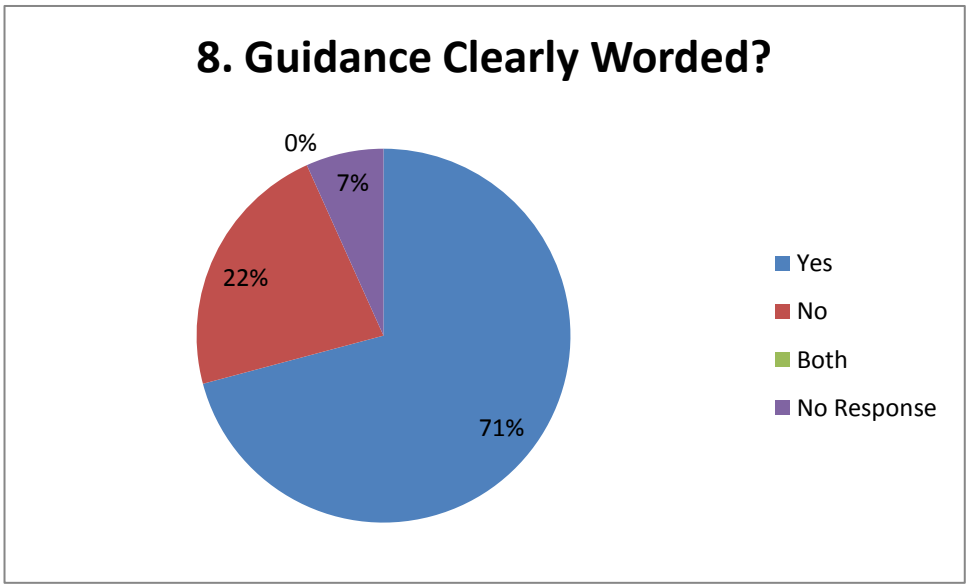
Do you think the guidance provided in the document is adequate?

Yes	150
No	56
Both	3
No Response	14



Is the guidance clearly worded?

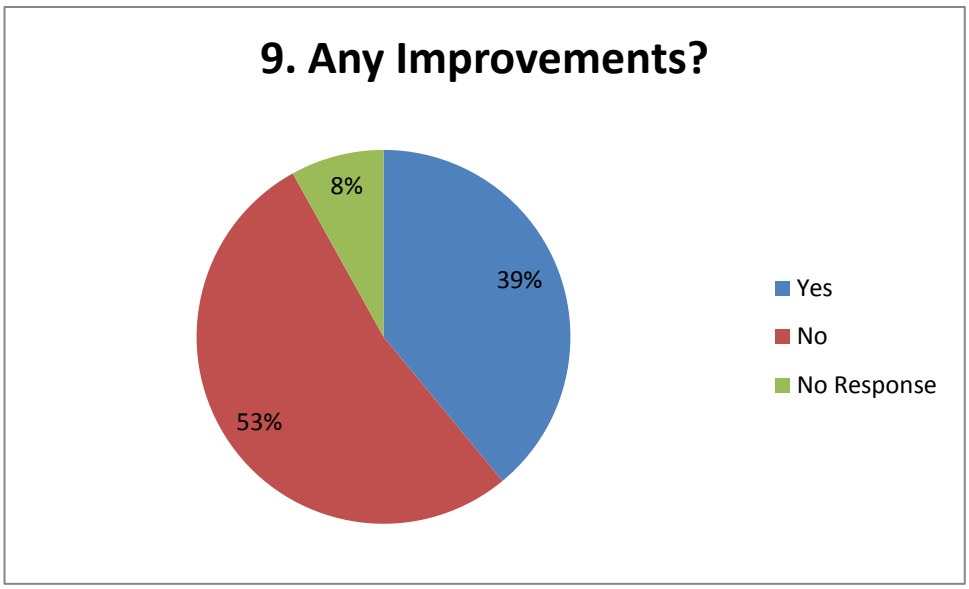
Yes	158
No	50
Both	0
No Response	15



4.4 General questions

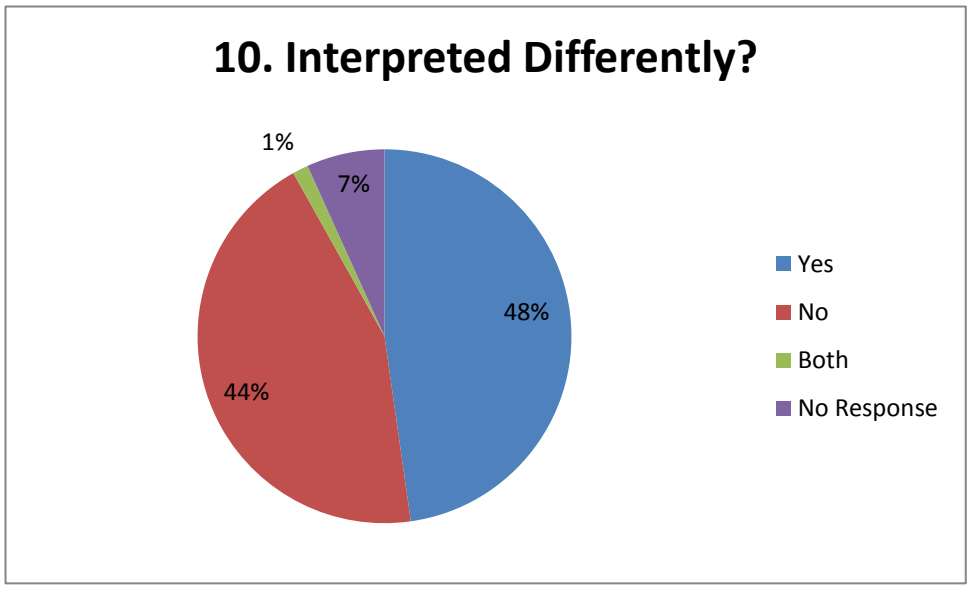
Are there any other suggestions you can make which you feel would improve the clarity of the document?

Yes	87
No	118
No Response	18



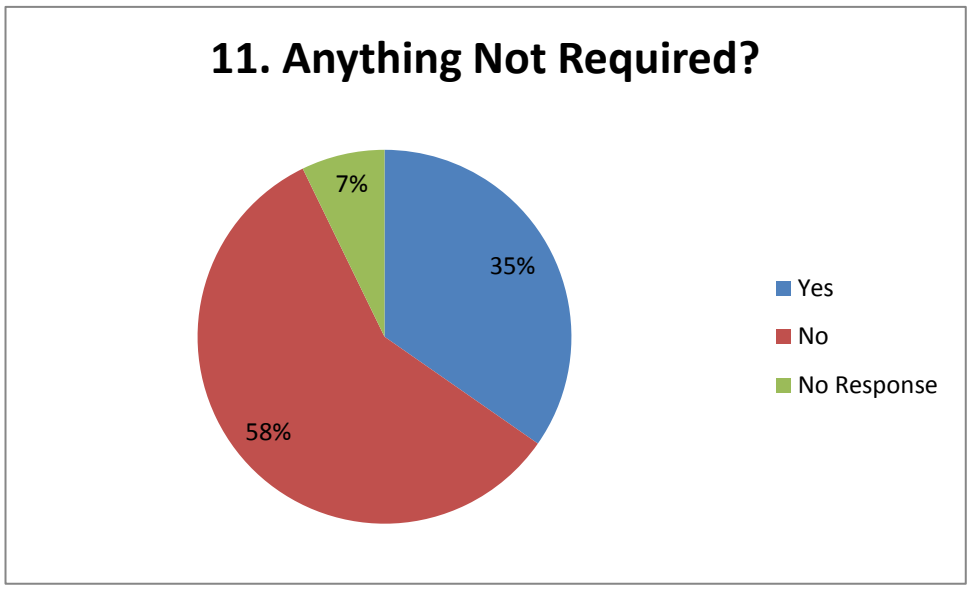
In your opinion, is there anything in the document that could be interpreted differently (either by osteopaths or by patients)?

Yes	106
No	98
Both	3
No Response	15



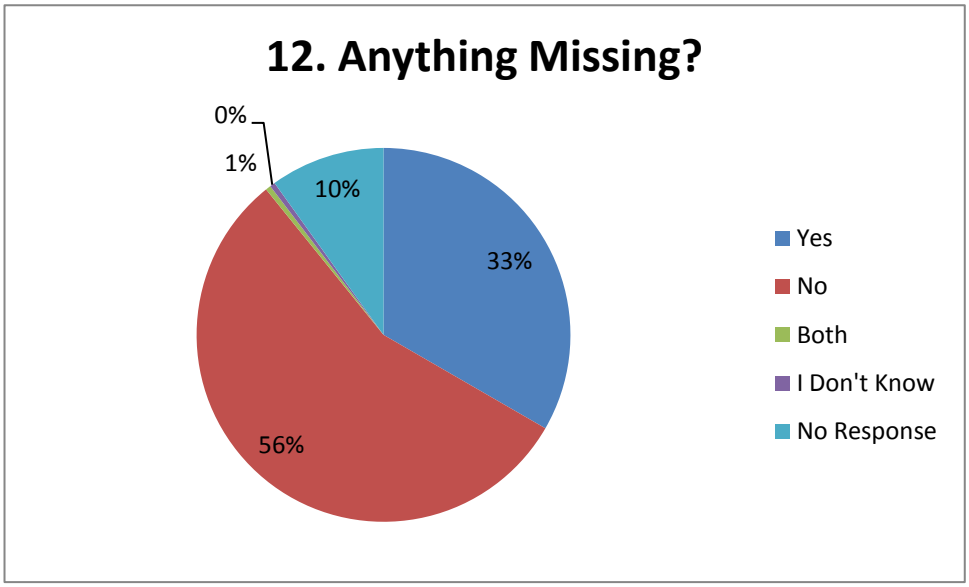
Is there anything in the document you consider is not required?

Yes	77
No	129
No Response	16



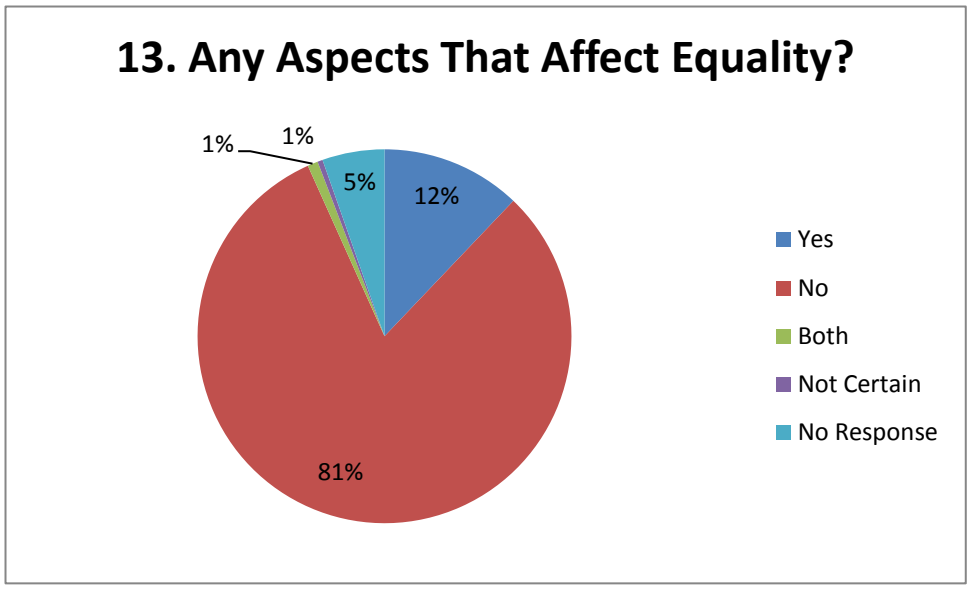
In your opinion is there anything missing from the document?

Yes	74
No	124
Both	1
I Don't Know	1
No Response	22



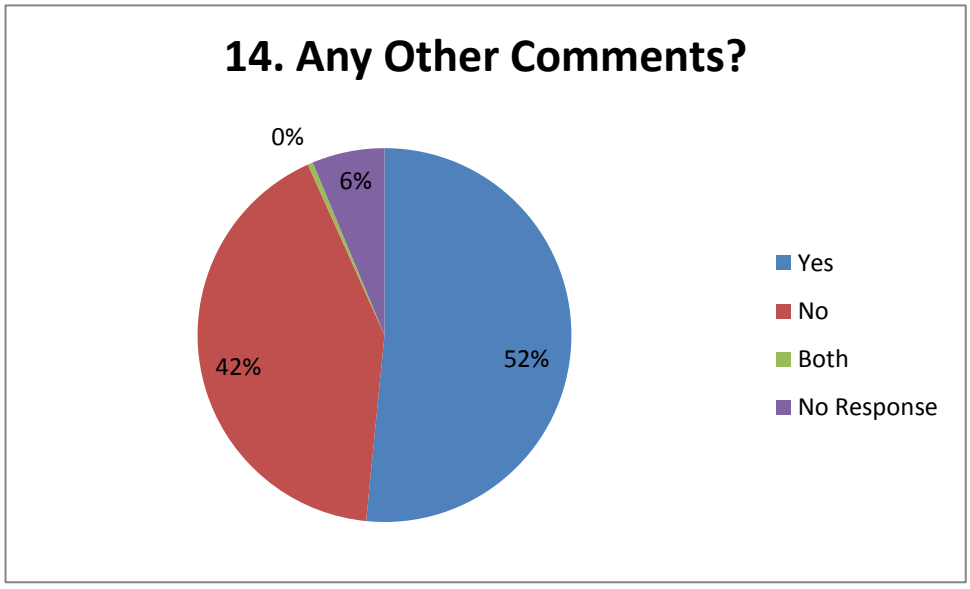
Once finalised, the revised Osteopathic Practice Standards will set the standards of practice expected of all osteopaths. With that in mind, are there any requirements included within the document that you think will adversely affect either osteopaths or members of the public in relation to gender, race, disability, age, religion or belief, sexual orientation or any other aspect of equality?

Yes	27
No	181
Both	2
Not Certain	1
No Response	12



Are there any other comments regarding this document that you would like to make at this time?

Yes	115
No	93
Both	1
No Response	14



Returning for a moment to the format of the document do you think it would assist at all if the left hand column was all put into a bold typeface?

yes	2
no	2
both	
no response	

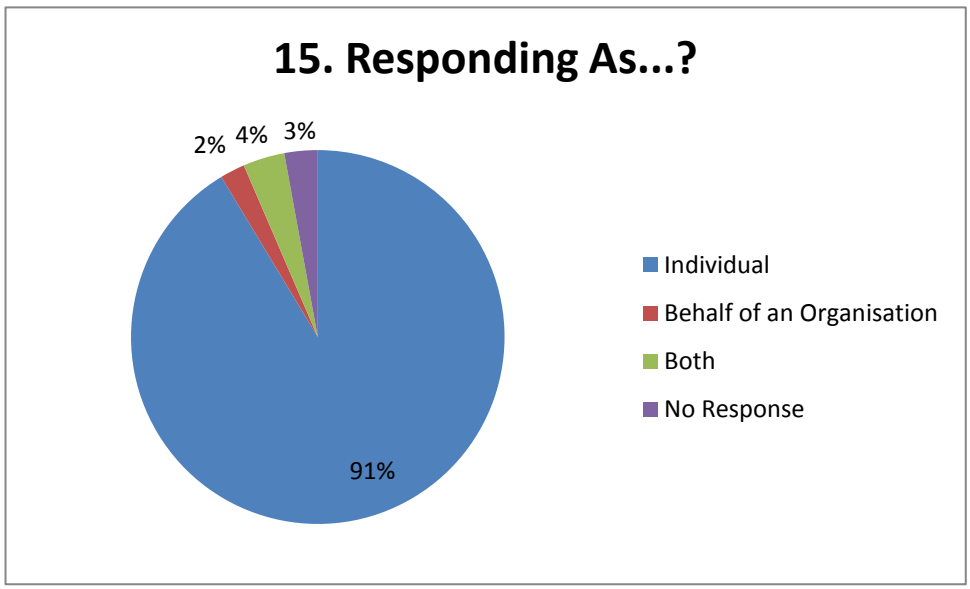
Is there anything in the document which you feel is particularly problematic because you work in an urban/rural setting?

Yes	1
No	2
Both	
No Response	1

4.5 Who responded to the consultation?

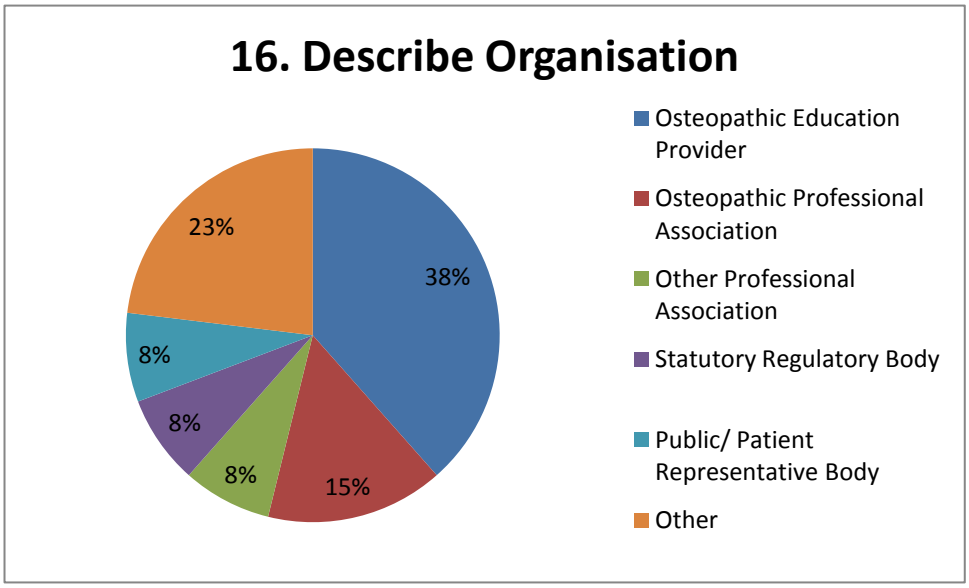
Are you responding as...?

Individual	127
Behalf of an Organisation	3
Both	5
No Response	4



Which category best describes your organisation:

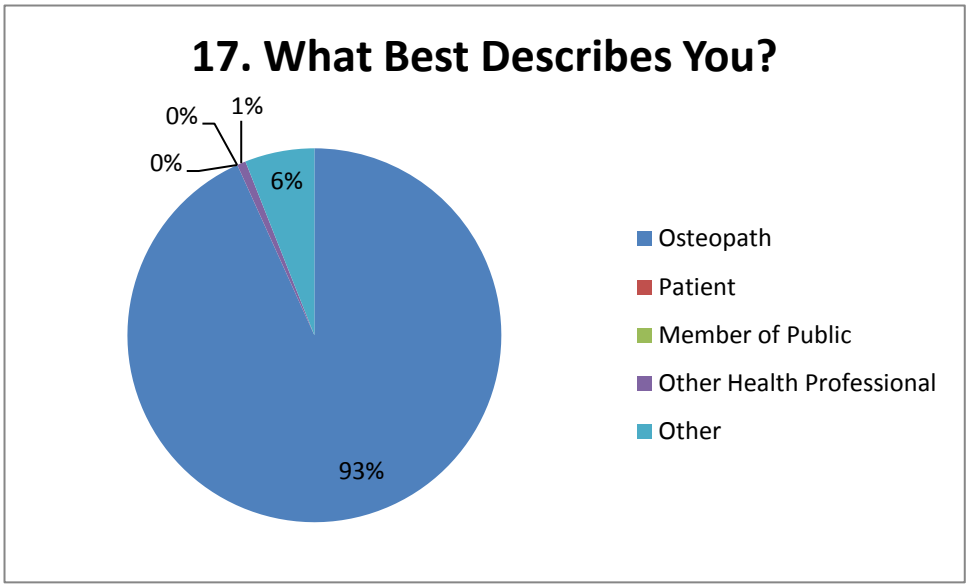
Osteopathic Education Provider	5
Osteopathic Professional Association	2
Other Professional Association	1
Statutory Regulatory Body	1
Public/ Patient Representative Body	1
Other	3



4.6 Questions for osteopaths

Which category best describes you?

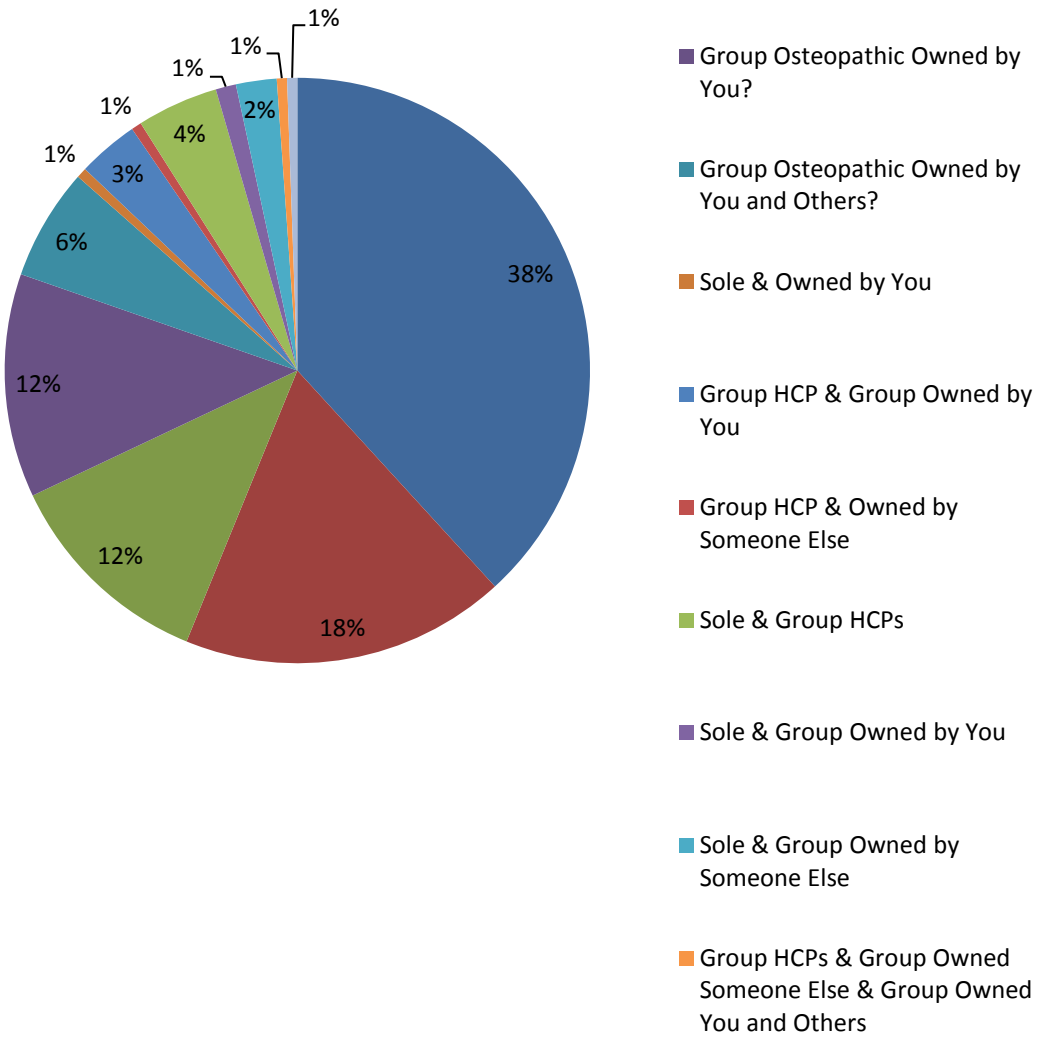
Osteopath	124
Patient	0
Member of Public	0
Other Health Professional	1
Other	8

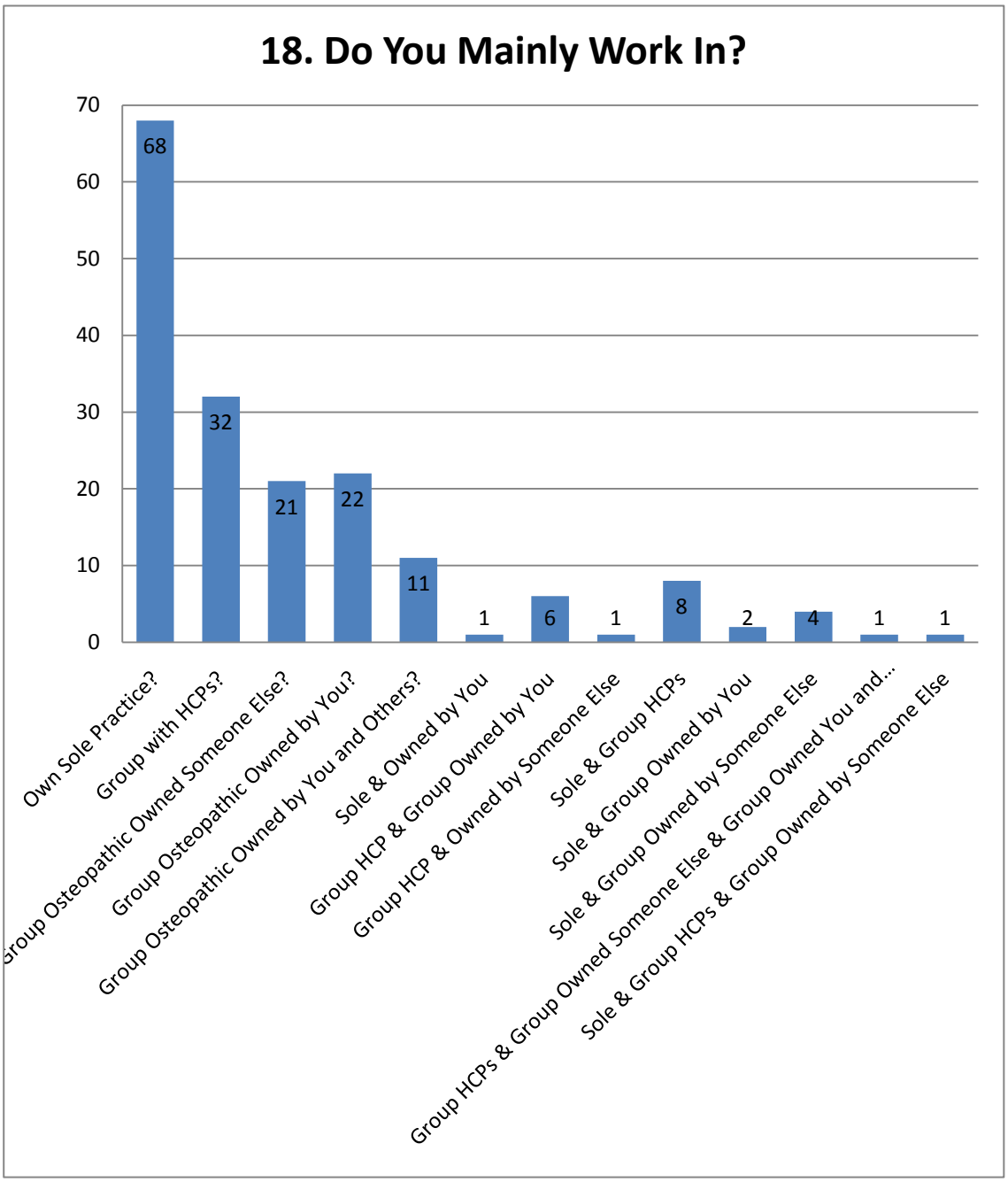


As an osteopath do you mainly work in:

1	Own Sole Practice?	68
	Group with HCPs?	32
	Group Osteopathic Owned Someone Else?	21
	Group Osteopathic Owned by You?	22
	Group Osteopathic Owned by You and Others?	11
2	Sole & Owned by You	1
	Group HCP & Group Owned by You	6
	Group HCP & Owned by Someone Else	1
	Sole & Group HCPs	8
	Sole & Group Owned by You	2
	Sole & Group Owned by Someone Else	4
3	Group HCPs & Grouped Owned by Someone Else & Group Owned by You and Others	1
	Sole & Group HCPs & Group Owned by Someone Else	1

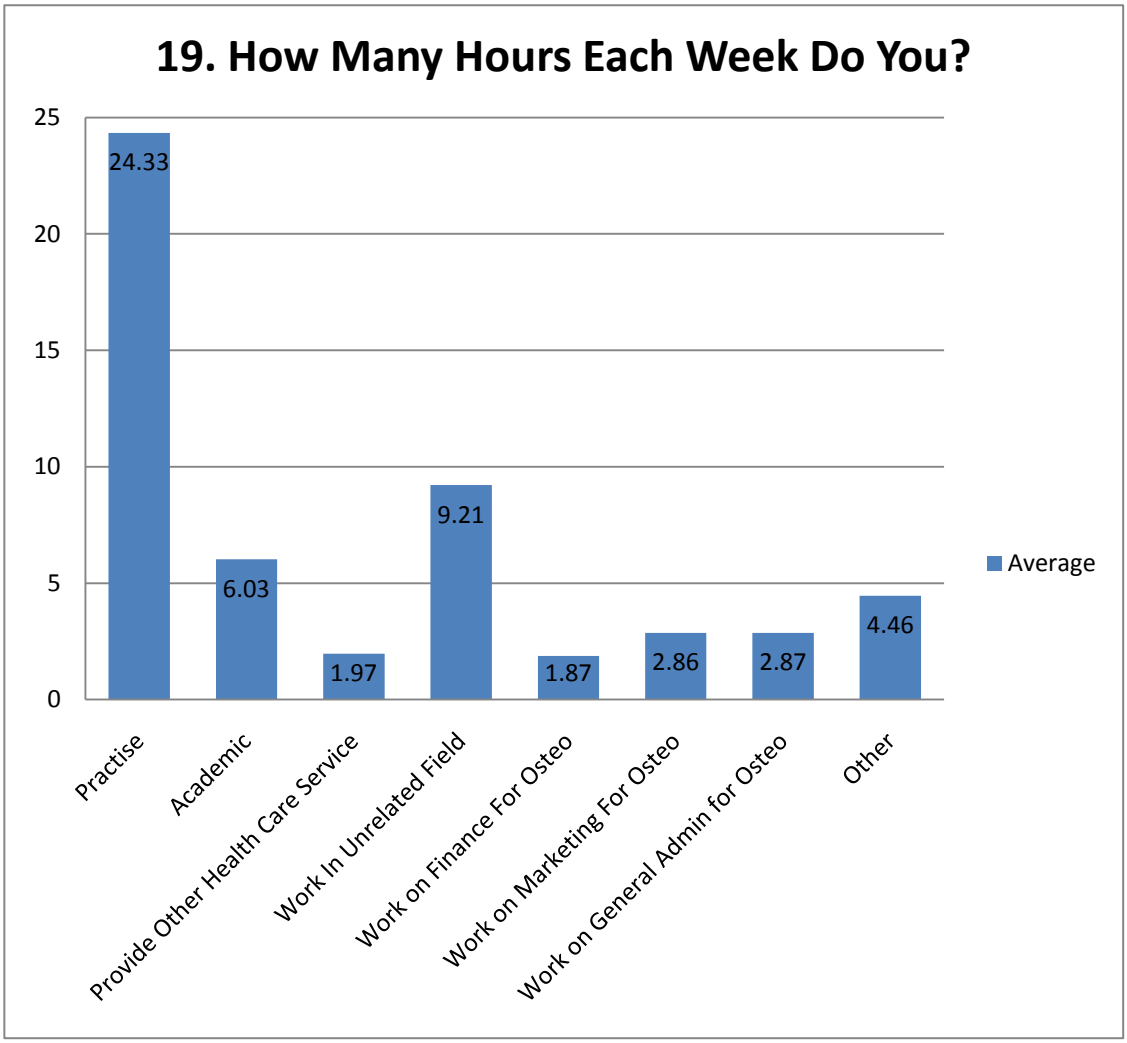
18. Do You Mainly Work In?




18. Do You Mainly Work In?
70
60
50
40
30
20
10
0
68
32
21
22
11
1
6
1
8
2
4
1
1
Own Sole Practice?
Group with HCPs?
Group Osteopathic Owned Someone Else?
Group Osteopathic Owned by You?
Group Osteopathic Owned by You and Others?
Sole & Owned by You
Group HCP & Group Owned by You
Group HCP & Owned by Someone Else
Sole & Group HCPs
Sole & Group Owned by You
Sole & Group Owned by Someone Else
Group HCPs & Group Owned Someone Else & Group Owned You and...
Sole & Group HCPs & Group Owned by Someone Else

As an osteopath please specify how many hours each week do you:

	Total of hours	Number of people	**Average (2dp)**
Practise	3698.5	152	**24.33**
Academic	488.4	81	**6.03**
Provide Other Health Care Service	29.5	15	**1.97**
Work In Unrelated Field	175	19	**9.21**
Work on Finance For Osteo	130.7	70	**1.87**
Work on Marketing For Osteo	180.2	63	**2.86**
Work on General Admin for Osteo	270	94	**2.87**
Other	53.5	12	**4.465**

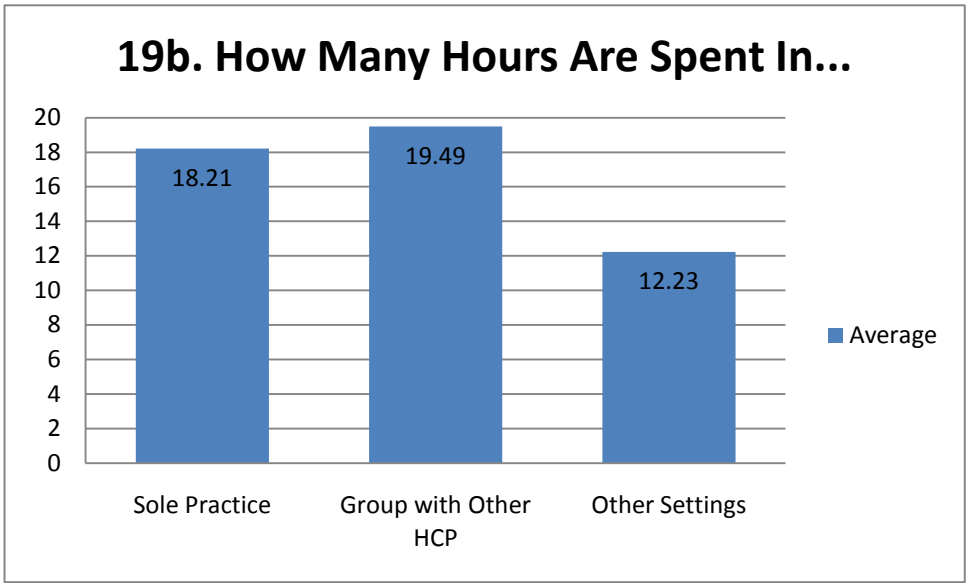


Other (please specify):

- running/ walking for exercise classes
- expert witness
- 16 hours developing courses and teaching approximately post graduate 3 courses a year. Considerable preparation involved
- Scottish Osteopathic Society Journal Editor and committee member as necessary
- volunteer in various healthcare roles
- practice management
- 4 days in an OEI. One day in practice.
- full time PhD student (25-30 hrs) lectures 8 hours, practise 3-5 hours
- laundry, cleaning property
- follow up with phone calls etc. From patients relating to enquires etc.
- administration includes writing letters to thank GPs for referrals, sorting out banking and accounts
- osteopathy assoc. and sports field
- supervision
- travelling
- regional society
- work for GOsC
- property maintenance (2hr) purchase of treatment consumables (1hr)
- 50% of practise is with animals
- practise has full time receptionist (=40hr admin)
- teach post grad classes (20 hr contact time)
- medical research – university and NHS. Can be much more *(than 10 hours*) when conducting clinical trials.
- Yoga teacher

Thinking about the total number of hours you have said you practise osteopathy, how many of those hours are:

	Total of hours	Number of people	**Average (2dp)**
Sole Practice	1547.95	85	**18.21**
Group with Other HCP	1598.3	82	**19.49**
Other Settings	134.5	11	**12.23**

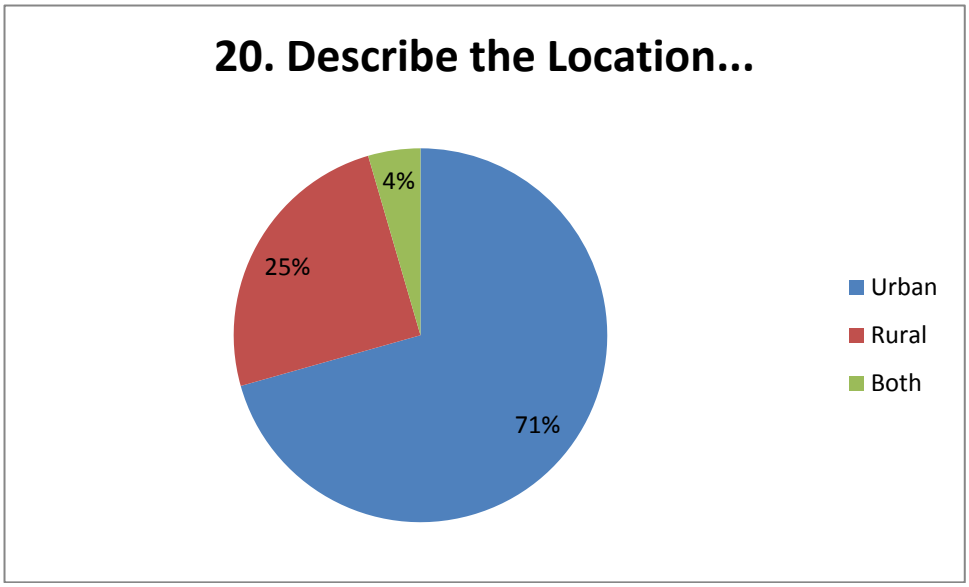


Please specify:

- other Osteo's & complementary health practitioners
- rent rooms in a gym & Pilate's studio. have contact with "body workers" not osteos
- group practice
- education
- with physio
- treating animals
- football club
- home practice with husband
- teaching and examining for OEIs, and work for GOsC
- sole associate osteopath

Would you describe the location of your main location as:

Urban	125
Rural	44
Both	8



What proportion of your practice is funded by:

Patients – 23 respondents said 100%
2 respondents said 99%
2 respondents said 98%
3 respondents said 97%
28 respondents said 95%
1 respondent said 92%
1 respondent said 90+%
49 respondents said 90%
1 respondent said 89%
5 respondents said 85%
1 respondent said 84%
1 respondent said 82%
18 respondents said 80%
7 respondents said 75%
2 respondents said 74%
9 respondents said 70%
2 respondents said 65%
1 respondent said 62.5%
4 respondents said 60%
3 respondents said 50%
3 respondents said 40%

1 respondent said 34%

Private Medical Insurer –

1 respondent said 60%
2 respondents said 50%
2 respondents said 40%
1 respondent said 38%
8 respondents said 30%
9 respondents said 25%
13 respondents said 20%
4 respondents said 15%
45 respondents said 10%
5 respondents said 8%
1 respondent said 6%
33 respondents said 5%
4 respondents said 3%
5 respondents said 2%
4 respondents said 1%

NHS –

1 respondent said 33%
1 respondent said 30%
2 respondents said 20%
1 respondent said 12.5%
2 respondents said 10%
1 respondent said 2%
2 respondents said 1%

Other 3rd party –

2 respondents said 20%
1 respondent said 10%
1 respondent said 7%
1 respondent said 4%
3 respondents said 3%
3 respondents said 2%
3 respondents said 1%

Not paid for –

1 respondent said 50%

8 respondents said 10%

1 respondent said 7%

3 respondents said 5%

1 respondent said 4%

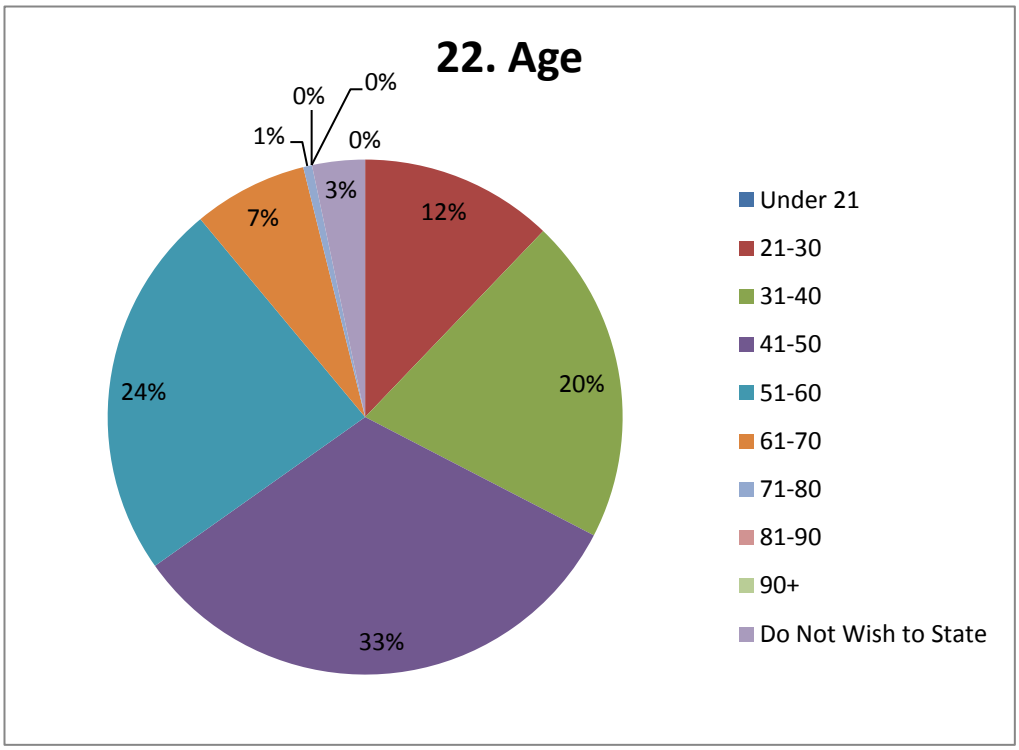
2 respondents said 2%

6 respondents said 1%.

4.7 Questions for all individuals

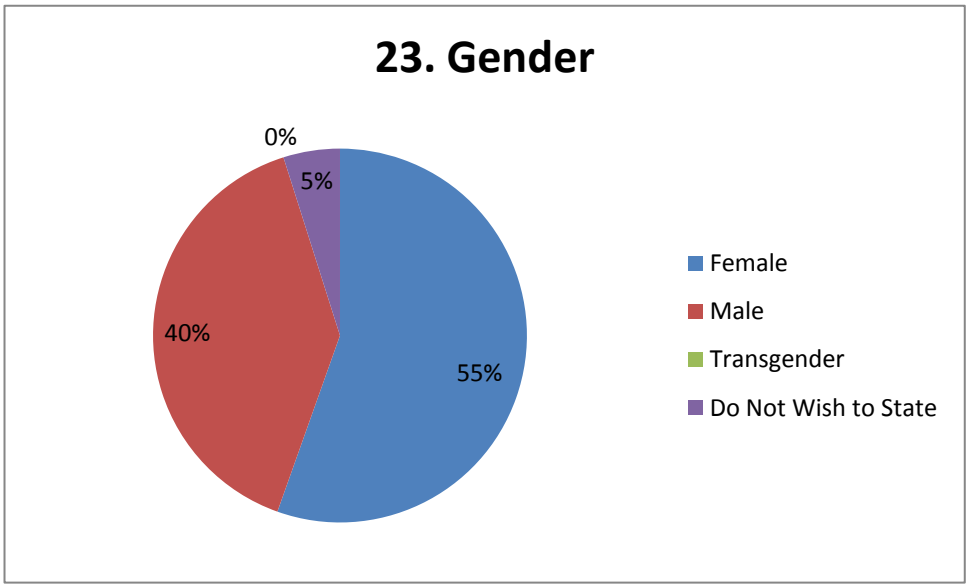
Age - Are you:

Under 21	0
21-30	22
31-40	37
41-50	59
51-60	43
61-70	13
71-80	1
81-90	0
90+	0
Do Not Wish to State	6



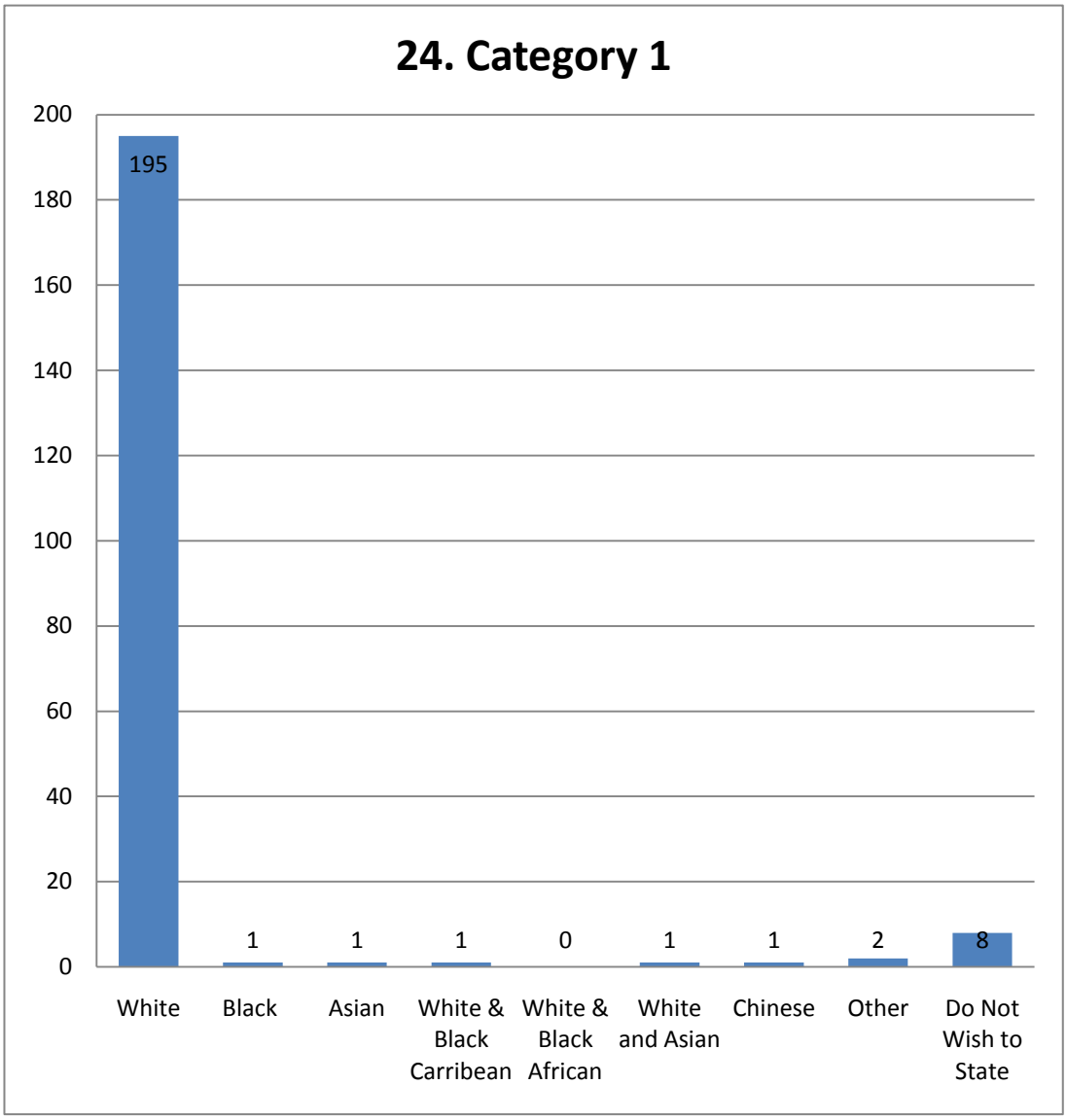
Gender - Are you:

Female	102
Male	73
Transgender	0
Do Not Wish to State	9



Ethnic Origin - Are you:

White	195
Black	1
Asian	1
White & Black Caribbean	1
White & Black African	0
White and Asian	1
Chinese	1
Other	2
Do Not Wish to State	8

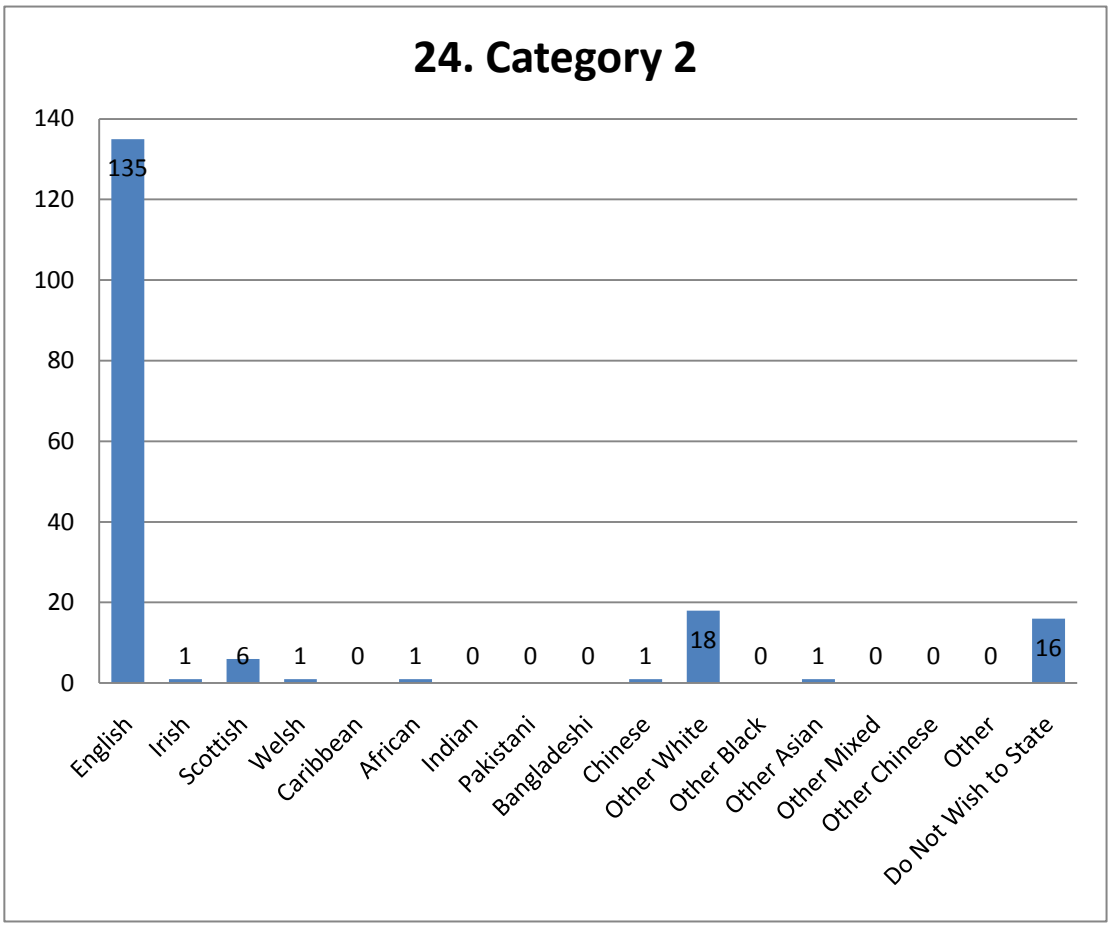


Other:

- white black Caribbean, Spanish

Category 2:

English	135
Irish	1
Scottish	6
Welsh	1
Caribbean	0
African	1
Indian	0
Pakistani	0
Bangladeshi	0
Chinese	1
Other White	18
Other Black	0
Other Asian	1
Other Mixed	0
Other Chinese	0
Other	0
Do Not Wish to State	16

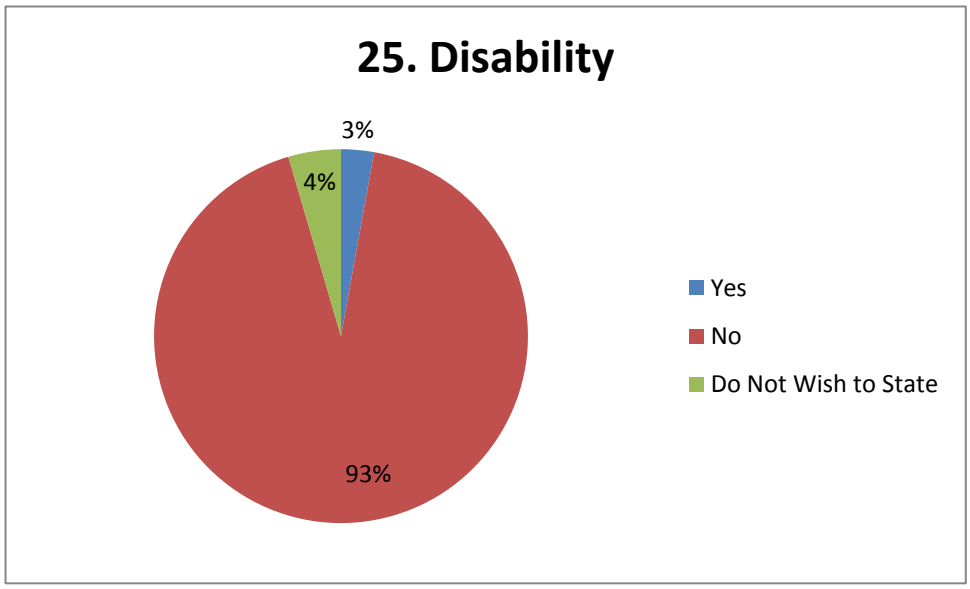


Specify:

- Portuguese
- Norwegian
- European
- eastern European
- British
- Danish
- French
- British polish decent
- French
- Zimbabwean
- Indian/Pakistani
- Northern Ireland
- Born in Argentina. British citizen since 1979

Do you have a disability?

Yes	5
No	163
Do Not Wish to State	8

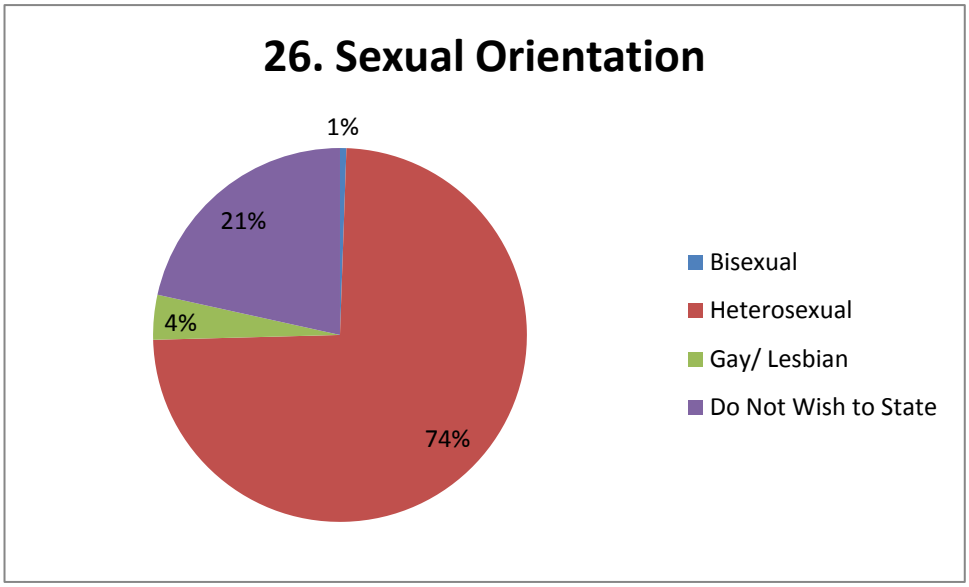


Nature:

- Diabetes and pulmonary hypertension, for which I have to permanently use oxygen.
- Diabetic but not disabled!!
- dyslexic
- severe migraines
- mild dyslexia

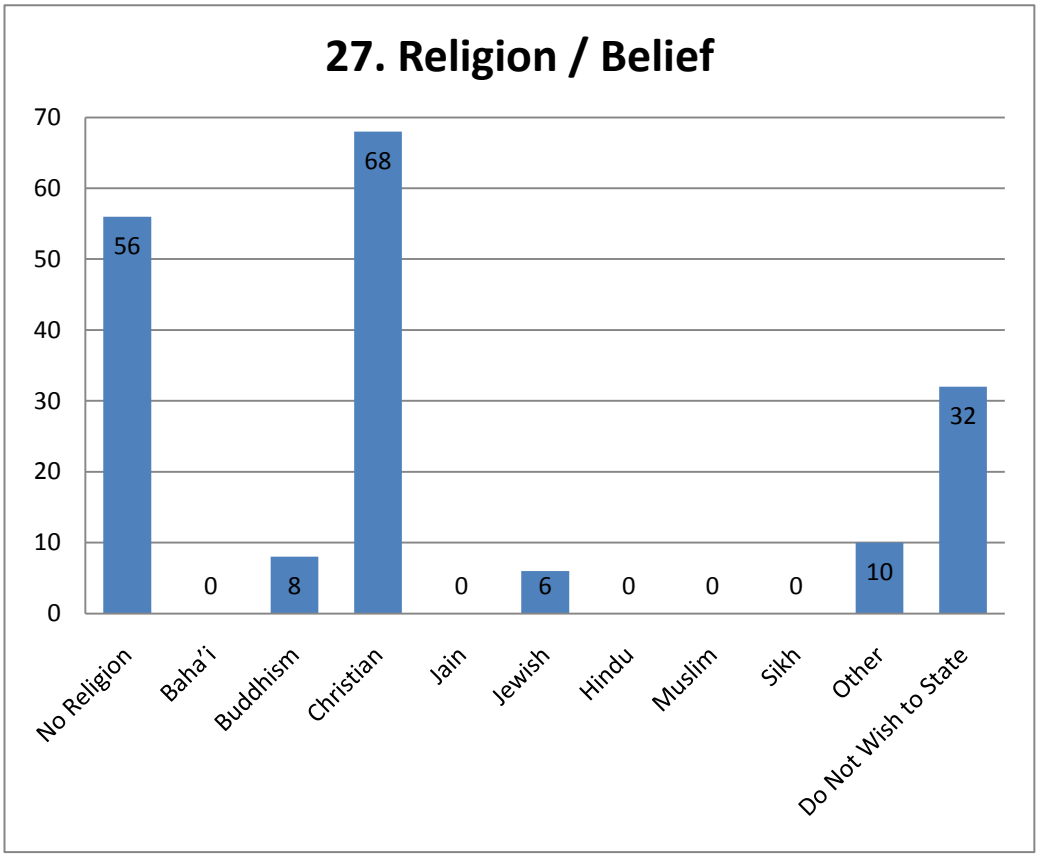
Please identify your sexual orientation:

Bisexual	1
Heterosexual	134
Gay/ Lesbian	7
Do Not Wish to State	39



Please identify your religion/ belief:

No Religion	56
Baha'i	0
Buddhism	8
Christian	68
Jain	0
Jewish	6
Hindu	0
Muslim	0
Sikh	0
Other	10
Do Not Wish to State	32



Specify:

- Quaker
- atheist
- Spiritual but not religious
- Druidry
- my own spiritual path
- mixture
- holistic/Gnostic
- spiritual
- non practising catholic
- agnostic

5 Our approach and ethics

Our suggested approach was to undertake the project in 4 main phases:

- Phase 1: briefing and planning
- Phase 2: development of consultation document
- Phase 3: consultation
- Phase 4: analysis and reporting.

In our original proposal we suggested the following combination of consultation methods for consideration:

- Electronic questionnaire addressed specifically to the GOsC registrant/student
- Telephone interview
- Face to face interview
- Focus group consultation meetings.

After discussions with the GOsC project managers and their colleagues, this combination of consultation methods was agreed with one change. That change was that the electronic questionnaire would not be addressed specifically to a named individual, but would be available to complete on the GOsC website with the responses being returned directly to us. It was also agreed that the consultation exercise would be 'publicised' in a variety of ways including:

- Notification directly to registrants and other stakeholders
- Articles in specialist publications
- Inclusion in GOsC e-publications and newsletters
- Strap line on outgoing e-mails.

Our plans with regard to telephone and face to face interviews, were that we would use a stratified sample in order to ensure that we did have an appropriate cross section. Osteopaths self selected to attend focus group meetings and respond electronically.

In addition GOsC contacted by letter a number of patient representative groups informing them of the consultation and we contacted all Osteopathic Educational Institutions and Post Graduate Education Training Providers with the aim of completing interviews with them.

It was explained in all correspondence, publicity and contacts made in relation to the consultation that respondents would remain anonymous unless they requested otherwise and, all responses to the consultation came directly to us as consultants for the project.

It was hoped that the consultation might be able to begin in August, however in reality it did not get fully underway until the 1st September when the consultation document was put up onto the GOsC website. This still allowed a full three months for consultation as the completion date for the consultation period, was agreed as the 30th November 2010. This we had felt would be sufficient time and, in theory we still consider this to be an adequate amount of time. Unfortunately acceptable dates (for respondents) for the focus groups and telephone interviews was very much towards the end of this period and indeed a number of telephone interviews were actually completed just after the end date. This of course had an effect on the entire project resource planning and the project completion timing.

We were specifically requested by GOsC project managers to give consideration to the ethical aspects of the project. In order to do this appropriately we requested our colleague Dr Ailsa Benson complete this.

Dr Benson has worked for over twenty years in training and education in health care and she completed her PhD in Healthcare Ethics in July 2006. Currently she provides 'a patient and public' voice to a NHS PCT.

Dr Benson commented as follows on the ethical conduct of the consultative research process itself:

Key considerations for the ethics of research relate to: - the need for the protection of the anonymity and confidentiality of the participant; the informed consent of each participant; and the management of the process itself. For this project, meeting these considerations were realised satisfactorily through two methods: the written introduction to the consultation questionnaire itself and the researchers professional approach. For patients, should they be contacted directly to be involved it would seem appropriate to provide a letter to support verbal information provided.

The anonymity of the registrant participants has been protected in several ways:

- Participants were selected through the consultants making a random selection from a registrants data base provided by the Council
- Records made by researchers at the time of the interview and subsequent transcription contain no identifying marks (i.e. name, address, post code, date of birth, place of employment)
- Final report makes no attribution to individuals
- Interviews, conducted by telephone, were at a time and location selected by the participant maximising control over privacy of the location
- Telephone interviews reducing the chance of subsequent identification by the researcher.

The Informed consent was addressed through:

Participants being told (via the information on the questionnaire introduction and repeated at the time of interview):-

- the purpose of the research
- who was funding the research and how the data from it would be used
- their right to refuse participation and/or to terminate the interview and/or not to answer any question
- how anonymity and confidentiality were to be protected (including no attribution in the final report)
- the research team and their independence and impartiality from the funders.

Additional matters

- It is not possible to comment on whether participants were using employer time and resources without permission
- The 'pre-booking' of interviews at a time convenient to the participant also gave them time to read the actual consultation document itself
- There appears to be no (or very minimal risk) in this research of harm or psychological trauma to a participant

Following conversations with the lead consultant for the project, I am satisfied that the researchers employed by the consultants are fully aware of the necessary ethical considerations in the manner of conducting the interview, transcribing and reporting.

There are two recommendations:

- That the consultants have signed confidentiality agreements with their researchers which includes information from those researchers about:

- how their records (electronic and paper) are kept secure
- once the project has been completed deletion/destruction of all records is confirmed

➢ That participants are given the opportunity to:

- See and comment on transcripts arising from their own interview
- Receive a copy of the final report.

The same considerations (about anonymity and consent) should apply to any patients who offer to respond to the consultation. Patients commenting on the proposed standards should receive the same questionnaire (with its introductory comments) as registrant participants as well as a specific letter. The latter provides additional reassurances about anonymity and confidentiality and how the responses would be reported to the Council. There is a, slight, potential risk for patients participating in such surveys to be reminded of a past bad experience. Patients should therefore be advised to contact the lead consultant if this happened, who is competent to provide a listening ear and manage as necessary.

6 Thoughts and recommendations

Having completed this consultation exercise, we have now given consideration to aspects which worked well and those which did not work as well, and based on this we present the following for consideration when completing future consultation exercises:

- The electronic aspect of the consultation was directly linked to the GOsC website and a number of respondents experienced considerable difficulty in forwarding their completed responses, a number stated that this was a problem they had encountered before with previous consultations. We would strongly recommend that this issue be looked at and resolved prior to any future electronic consultation. We suspect that some responses were lost (although respondents may have thought it had submitted); that some respondents 'gave up' on trying to submit and some perhaps did not even attempt to respond if they had encountered difficulties in the past
- Although there was a questionnaire to complete, many respondents wanted to provide much more detail. This is of course extremely valuable but extremely difficult to collate and it became necessary to provide a huge amount of feedback separately, in order to ensure that valuable feedback was not lost. Careful consideration needs to be given to how this can most effectively be provided in the future
- In overall terms the response to the electronic aspect of the consultation was disappointing. This is of course a very cost efficient method of consulting, but that has to be weighed against the level and quality of response received. During this process we became aware that there is a strong core of osteopaths who do not like and, do not wish to 'work electronically'. We feel it is important that cognisance is taken of this information in future consultations
- In establishing suitable dates and times for telephone interviews we encountered a number of challenges. In order to make initial contact with an osteopath we were on average having to make double the expected (and usual) number of calls. On average we were having to make 10 calls to obtain a commitment to a telephone interview. We also found that having agreed a date and time for the telephone interview we had a considerably higher than usual 'drop out' rate. All of these points add to the resource requirements and again need to be considered in any future

consultation. That said the feedback received via telephone interviews was generally of very high quality. We offered to complete telephone interviews outside usual working hours (early morning, evenings and weekends), we were surprised that this offer was very rarely taken up

- A total of 183 osteopaths attended focus group meetings. This is a very good response to this method of consulting, and is a higher number than we had originally expected. There were thirteen dates for meetings and they were held in different locations around the UK. The majority of the meetings were organised by representatives of the GOsC Regional Communications Network and we would like to thank them for assistance in making this aspect of the consultation process so successful. In the main using the Regional Communications Network was successful, but this was not true for all areas. It should also be noted that we did not attempt to offer focus groups in all regions covered by the Network
- Although we recognise that consulting by focus group is relatively costly, our observation is that this is probably the preferred route for many, and the feedback at these meetings was generally of very high quality. In addition it allowed individual osteopaths to debate and discuss their opinions with others which they appeared to consider valuable and, certainly we felt added to the quality. We would suggest that in future, attempts should be made to ensure that numbers of attendees are known well in advance of the meeting if at all possible, and that rooms used for such meetings are adequate to accommodate the numbers attending, and the numbers of facilitators required to obtain optimum input from attendees. We make this recommendation as there were occasions when ideally we would have provided more facilitators had we been aware of numbers and had space been available to allow for the facilitation of more than one group
- We mentioned in other sections the point that there seemed some misgivings about the purpose of the document. We did obtain the distinct impression that many osteopaths do not fully understand the role of the Regulator and there was some confusion around the differences between a Professional Body and a Regulator. We therefore feel that there could be considerable value in this being clearly and simply articulated in as many ways as possible
- We recommend that an osteopath who regularly treats animals is asked to give feedback on the document as we have not been able to obtain any specific feedback regarding the treatment of animals
- It was always accepted that patient feedback would be the greatest challenge and this was proven. Patient feedback is very important, but it is very difficult to identify a good argument for any patient or potential patient to read through such a substantial and arguably quite complex document and, then comment upon it. This clearly is a challenge which must be overcome for future consultation exercises. We suggest the following ideas for consideration:
    - GOsC establishes a number of patient groups. This would entail a not insubstantial resource to initially establish, but thereafter should pay dividends. The concern regarding such groups is that they have the potential to become too ‘cosy’ and close to the organisation which establishes them. In order to overcome this we would strongly recommend that the membership is changed regularly and we would suggest a maximum of a three year tenure. In addition we would suggest that a number of groups be established around the UK (alongside the Regional Communication Network), which will help to avoid ‘over reliance’ on too small a number of patients

- GOsC plan to establish strong working relationships with patient representative groups in order that representatives of those groups will respond to consultations regularly. This again will take a considerable time commitment but will potentially in the longer term be time saving
- GOsC establish a plan with their registrants (or some of them) in order that they will take responsibility to encourage patient feedback on consultations. The key concerns regarding this, are that it is putting additional demands on already busy osteopaths with arguably little reward for them and the feedback received may be skewed.

- We did plan our telephone interviews using a stratified sample in terms of geographical spread, male/female split and age. We requested a considerable amount of other personal data from recipients, which many (although not all) provided. We are unable to tell if this has been representative however, because currently the data base of registrants does not hold very much personal information. In order to ensure truly representative samples this additional data does need to be held
- Based on the feedback received we feel there would be considerable benefit in providing a clear explanation of what the 'standard' is, what the 'guidance' is and, how both would be used should a complaint be received
- We were often asked who was involved in the development of the new standards and often there were comments such as:

  'Clearly this has been written by bureaucrats'

  'Obviously there have been no osteopaths involved with this development'

  'There have been no educationalists involve'

  'Obviously educationalists wrote this'.

  We would like to suggest that in any future consultation it should be clearly stated how a document has been developed and who has been involved.

We have also given consideration to the issue of ethics within the document being consulted upon. In requesting that Dr Ailsa Benson review this aspect specifically we have in effect the opinion of another 'stakeholder'. Dr Benson is qualified to offer such comment in our opinion by way of having worked for over twenty years in training and education in health care and having completed a PhD in Healthcare Ethics. In addition she currently provides 'a patient and public' voice to a NHS PCT.

We have split this feedback into four sections: introduction; general remarks and observations; a discussion of where further ethical considerations could be incorporated and finally some concluding remarks.

Introduction:

Health professional regulatory bodies were set up to protect and promote the safety of the public. The Council for Healthcare Regulatory Excellence states that they do this by:

- Setting the standards of behaviour, competence and education that health professionals must meet

- Dealing with concerns from patients, the public and others about health professionals who are unfit to practise because of poor health, misconduct or poor performance
- Keeping registers of health professionals who are fit to practise in the UK
- The regulators can remove professionals from their registers and prevent them from practising if they consider this to be in the best interests of the public.

This part of the report comments primarily on the ethical considerations relating to the first bullet point. Within Theme D there is guidance about managing complaints and the need to report concerns about impairment of self and (in C9) others to practice. The responsibilities of the regulators to keep registers and have in place procedures for removing from the register are, presumably, contained in other documents. Perhaps some reference to such documents would be appropriate in this one.

General remarks and observations:

The term ethics (and, for example, related terms such as ethical) are rarely used within the document. Such an approach can be valuable in that ethical considerations are incorporated, appropriately and naturally, into standards relating to the conduct, practice and professional behaviour expected of practitioners. On the other hand, thoughtful considerations about what is 'right/wrong' and/or 'good/bad' may be minimised.

The model of health care professionalism that appears to underline the Code of Practice is one which is responsive to the patient, presumably because in many cases the patient is contracting with the osteopath for care. Whatever the model of professionalism, it is at least in part related to expectations about the relationships between the patient and the professional and these are addressed within the standards.

There is a strong emphasis throughout on respect for the privacy and dignity of a patient, as well as respecting and creating their autonomy through active involvement in their own care. The ethical principles and values of professional behaviour and conduct, in relation to the patient and others including health care practitioners, are also incorporated. Furthermore, there are particular standards/guidance addressing the needs arising from patients who are children, mentally impaired, or with cultural/religious needs. 'Safeguarding' children and vulnerable adults is the subject of specific legislation.

The proposals are ethically robust in respect of the following ethical concepts and associated practice behaviours:

- Consent
- Confidentiality
- Privacy and Dignity
- Equality
- Records
- Virtues (care, integrity, honesty, trust).

The document is comprehensive and well set out. Deciding the format and structure is commonly problematic as some standards and guidance can 'fit' into more than one theme, especially in matters of ethics. Generally, the theme names are well chosen and each contains appropriate standards and guidance. But this sometimes means that 'full' ethical consideration is addressed across more than one theme.

Examples include:

- Consent – is addressed in both themes A and D
- Confidentiality (as addressed in D) is also important ethically for the trust within the patient partnership
- Communication skills are well described in A but of course are also important skills for reference in B
- Guidance and standards connected with patient records are addressed in A, C and D
- Treatment plan is referred to in both A and C.

Strategies to cope with this include:

- Cross referencing
- Mapping to show links
- Including guidance that themes are not self contained so that the themes, standards, code of practice and guidance need to be read as a whole rather than by cherry picking.

The selection of Communication and Patient Partnership as the first theme is a demonstration of the centrality of the patient to osteopathic professional practice. The early emphasis on the need for well developed interpersonal communication skills, and on listening to the patient, is especially worthy of note.

Potential opportunities for incorporating other ethical considerations into the standards:

Use of the term 'ethical' in a theme introduction

Two of the themes (A and D) have introductions that include the term 'ethical'. There is scope for adding 'ethical' into the introductions for both themes B and C since it is unethical to practice without the requisite knowledge and skills and attention to safety and quality.

By drawing on experience, knowledge and skills in judgements about the treatment for an individual patient, the practitioner both benefits and protects from harm that patient. Beneficence and non- maleficence are ethical concepts. The 'positive' nature of the former (contribute to the welfare of an individual), is contrasted with the 'negative' (e.g. do not cause suffering, do not cause offence) of the latter. The use of knowledge in a person centred way also draws on the virtues of care and compassion.

Doing 'good' can lead to paternalism and hence clashes with respect for the autonomy of the patient. However, generally, the emphasis on the patient, across these standards and guidance, moderates this potential tension.

The introduction to theme C does refer to the patient. But, it fails to do justice to the quality of the respect for patient dignity and to the care and compassion of the practitioner which are well expressed within the actual standards and guidance.

Theme D Professionalism

The following comments are intended to be helpful in clarifying some ethical considerations. Essentially, professionalism can be understood as the quality of doing the job well, and of following the appropriate standards (technical, legal and ethical) to meet the expectations of the particular occupational role.

Professionalism carries with it accountability for actions, including, in health care, an emphasis on the welfare of the patient. Where practitioners have accountability to others for the effective use of resources (for example, if treatment is funded by the NHS) then there is a need to also take into account the effect of the professional's own actions on the welfare of others and the wider society. That is, the 'utility' aspect of beneficence may extend beyond that of the special relationship with one patient.

Professional judgements are reflective of personal values and interpretations. D4 guidance could therefore usefully include a reminder that personal 'views' and 'values' are often ***hidden*** from conscious awareness. So self-awareness about personal values in decisions is necessary. Experience can also lead to a sense of the 'professional knows best', especially if a sole practitioner.

Whether or not to include conscience clauses within Practice Standards is often debated. But it may be appropriate for D4 and/or D5 to be balanced by such a clause. i.e. that if personal religious or moral/ethical beliefs prevent a practitioner from providing a particular service, then the professional body should be made aware of this and affected patients given a polite explanation and referred to another practitioner.

D7 guidance would be strengthened by respecting the need for patient information through the provision of visible leaflets/posters within each practice explaining procedures and contacts for complaints. It is helpful to balance this by encouraging 'compliments and comments' rather than just complaints.

Other points

Obtaining consent is, as A4, guidance 11 states, a legal requirement. It is also an ethical one – and which requires 'compliance' with the profession's own standards. The consent should always be informed.[1]

D6, guidance 8 and 9, concerns disclosure with and without consent. There are distinctions between legal requirements to disclose and legal permission to disclose

[1] i.e. given intentionally, with understanding of pros and cons; without controlling influence from others; through the provision of appropriate and sufficient information; and with choices.

which have ethical implications for patients. Whether or not patient consent is required, it may still be ethically appropriate to inform the patient about such actual or planned disclosure unless specifically prohibited (e.g. in a criminal investigation) or advisory (e.g. where a patient may become violent). And, whether disclosure is legally required or permitted then ethically disclosure should be proportionate and limited to the relevant details. Information Disclosure/Sharing Agreements exist between bodies such as the NHS, police, and Social Services within local authorities.

In the various standards and guidance relating to patient records, a surprising omission is the lack of an explicit ethical statement that patients should have the opportunity to see and access all records relating to their care. The active involvement of the patient in the treatment plan (A5) and the need to take account of their wishes (C2, guidance 2.3) could be enhanced by 'showing' or 'sharing' the actual treatment plan with the patient.

C9, guidance 21 and 22, is a valuable addition and an ethically important one to address. There is no direct reference to the ethically difficult situation where staff may need to raise concerns about the principal of a practice.

Concluding remarks:

Standards are necessary but not sufficient in themselves. The effectiveness of such standards generally is dependent on the extent to which registrants of the council are familiar with and draw on them. The role of the personal values of any one registrant in understanding and interpreting the standards should not be underestimated. Support through education and continuing professional development remains essential. Development of ethical and values literacy is enhanced by discussions with other practitioners about the justifications and rationale for exemplar decisions.

Any low response rate to the consultation may be indicative of failures (for whatever reasons) to read the proposed standards. There are thus potential implications about the familiarity with, and use of, the final version.