General Osteopathic Council

Report of the consultation outcomes in relation to updated *Osteopathic Practice Standards*

Contents

Introduction

1. This report presents an analysis of responses to the consultation held between 1 August 2017 and 31 October 2017 on the updated *Osteopathic Practice Standards*.

Background

2. The current *Osteopathic Practice Standards* were introduced in September 2012.

3. At its meeting of 12th November 2015, Council approved plans to review the *Osteopathic Practice Standards*. This was to involve a broad process of stakeholder involvement focussing on a 'call for evidence', desk based research, redrafting and further consultation on the revised draft standards.

4. At its meeting of 4 February 2016, Council approved fundamental principles to underpin the Osteopathic Practice Standards review. These principles are:

    a. The existing four themes for the *Osteopathic Practice Standards* should be retained. These are; Communication and patient partnership; Knowledge, skills and performance; Safety and quality; Professionalism.

    b. The *Osteopathic Practice Standards* should continue to comprise both the *Code of Practice* and the *Standard of Proficiency*, standards specified in the Osteopaths Act 1993.

    c. A call for evidence, using a diverse range of communications, should target all stakeholders.

    d. A reference group comprising a range of stakeholders should be engaged to ensure a balanced approach to the analysis of pre-consultation feedback and the development of new draft standards.

5. The initial call for evidence took place in 2016, using a dedicated website to seek views on the current *Osteopathic Practice Standards*. Responses to this were analysed and used to inform the development of updated standards in collaboration with a Stakeholder Reference Group. This group is made up of representatives from:

    - The Council for Osteopathic Educational Institutions
    - The Institute of Osteopathy
    - The National Council for Osteopathic Research
    - The Osteopathic Alliance
    - Patients

Consultation process

6. The consultation on the updated *Osteopathic Practice Standards* took place between 1 August 2017 and 31 October 2017. The main channel for respondents to give their feedback was online via a dedicated interactive

consultation website. This was used to publish the updated standards with an embedded consultation form comprising 16 questions. Throughout the consultation period, efforts were made to raise awareness of the consultation and encourage respondents by linking to the dedicated website. Responses could be made online via the website, or by email. The standards document and the full consultation document could also be downloaded, or a hard copy could be supplied on request.

Response rate

7. Total respondents via the consultation website was 227 with 91 emails, making a total of 318 overall.

Other engagement activities

8. In addition, a number of engagement activities were held. These included:

- Patient focus group
- Meeting with osteopathic educational institutions
- Presentation to senior faculty members at the University College of Osteopathy
- Presentations to regional osteopathic groups (Scotland, London, Kent and East Sussex, Wessex, Western Counties, Bedfordshire)
- Presentations with students (British College of Osteopathic Medicine, Swansea)
- Direct feedback from policy officer on the GMC standards and ethics team
- Web meeting with registration assessors/education visitors
- GOsC stand at the iO annual convention
- Development of a toolkit which encouraged groups to work through the consultation together.

Channels used

9. Communications channels used included:

- Social media/Video
- GOsC website
- Ozone
- Dedicated email x 3
- Email to stakeholders x 3
- E bulletin x 3
- Dedicated website
- 2 issues of *the osteopath*
- Face to face engagement
- Tell us what you think' promotional flyer
- Banners and content shared in stakeholder communications (iO newsletter and magazine Healthwatch, OEI Social media)
- Toolkit

Target Audience

10. The aim was to gather feedback from a broad range of stakeholders, including osteopaths, patients, osteopathic organisations and other healthcare professionals or organisations. Respondents to the online consultation were asked to indicate in which role they were responding. The following table summarises the responses from those who chose to answer this question:

Osteopath	119 respondents
Lay partner of PCC	2 respondents
Local Osteopathic Group	2 respondents
Member of the public	1 respondents
Osteopathic Educational Institution	1 respondents
Osteopathic educator	1 respondents
Other	1 respondents
Other healthcare professional	1 respondents
Patient	1 respondents

11. Respondents were also asked their gender and age range. The following summarises the numbers of those who responded to this:

Male	40
Female	77

Age range	**Respondents**
21 – 30	7
31 – 40	10
41 – 50	40
51 – 60	47
61 – 70	16

12. The social media reach in relation to the consultation was monitored:

YouTube	544 video views
Facebook	Highest reaching post was 2,663
Twitter	Top tweet earned us 1,585 impressions

Summary of Consultation responses

13. Table 1 summarises the responses received in relation to each of the consultation questions 1-3 and 5-16. The response to question 4 (which is in a different format) in shown in Table 2.

14. The report then provides a description of the responses collected according to each of the consultation questions both quantitatively and qualitatively, to give a flavour of the types of responses made and, where appropriate, themes arising.

15. As well as the responses made via the consultation website and emails, reference is also made to discussions held at the various engagement events when additional insight to some of the consultation themes can be provided by this method of engagement. Notes of such events were taken and used to inform the consultation analysis. A graphic overview of the consultation process is depicted below in figure 1.

Figure 1 – overview of consultation process

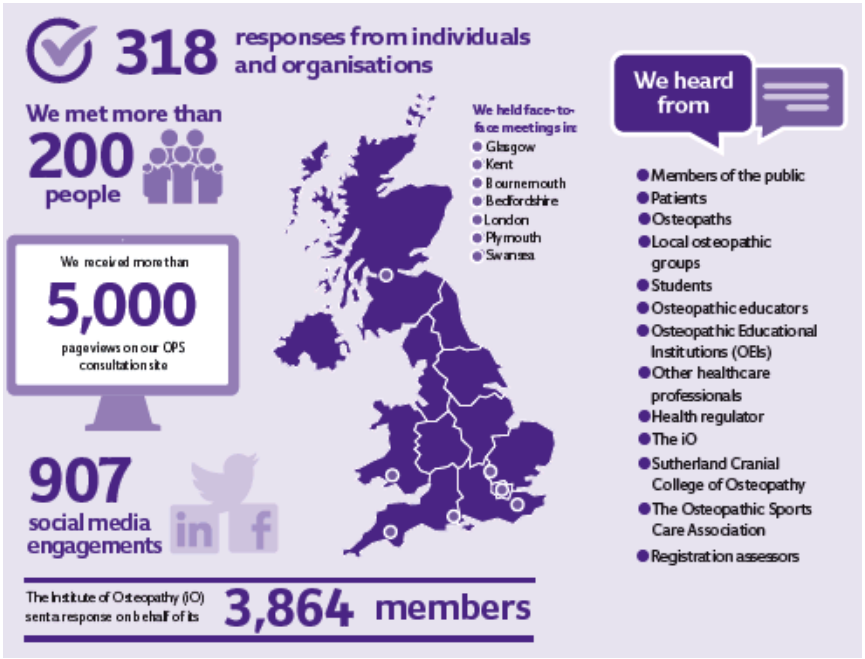

Table 1 responses (excluding question 4)

Question	Yes	No	no 'Yes or No'
1. Do you support the structure of the proposed updated Osteopathic Practice Standards?	122	10	
2. Do you feel that the content of the standards and guidance in the updated Osteopathic Practice Standards is accessible and clearly worded?	103	23	
3. In relation to standard A4, is the guidance sufficient to support the implementation of this standard?	95	19	
4. See table 2 below			
5. Is updated standard B4 and its supporting guidance sufficiently clear and easy to use?	116	15	
6. Is updated standard C2 and its guidance sufficiently clear and easy to use in relation to the recording of patient information?	127	6	
7. Is updated standard C3 sufficiently clear and easy to use?	105	10	
8. Do you feel that updated guidance to standard C6 is clear and adequately sets out the appropriate position of osteopathy in relation to the promotion of public health?	61	23 4	
9. Is updated standard D2 and its supporting guidance sufficiently clear and easy to use?	114	15	3
10. Is updated standard D3 and its guidance in relation to the duty of candour sufficiently clear and easy to use?	113	9	3
11. Is updated standard D5 and its guidance sufficiently clear and easy to use in relation to the maintenance of patient information?	118	8	
12. Do you feel that updated guidance to standard D10 is clear and adequately sets out the appropriate position of osteopathy in relation to other healthcare providers?	110	10	1
13. In your opinion is there anything missing from the document?	25	90	1
14. Are there any suggestions you can make which you feel would improve the clarity of the document?	24	83	4
15. Are there any other comments regarding this document that you would like to make?	24	71	6
16. Are there any aspects of the proposed updated Osteopathic Practice Standards 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 aspects of equality?	8	10 1	

Table 2 responses – Question 4

4. What is your preferred option for referencing osteopathic philosophy and principles?	**Q4 Option 1 – principles and philosophy as a standard**	**Q4 Option 2 – principles and philosophy in guidance**	**Q4 Option 3 – Remove reference to principles and philosophy**
	243	45	8

Question 1: Support for the structure of the proposed updated Osteopathic Practice Standards

16. Question 1 related to the overall structure of the updated standards, in particular:

    a. The combining of the Standard of Proficiency and the Code of Practice into one set of standards.
    b. The retention of the current four themes of the Osteopathic Practice Standards
        - Communication and patient partnership
        - Knowledge, skills and performance
        - Safety and quality in practice
        - Professionalism

1. Do you support the structure of the proposed updated Osteopathic Practice Standards?	**Yes**	**No**
Response rate	**122**	**10**

17. Respondents supported the structure of the proposed OPS in terms of its clarity, navigability and the language adopted throughout document (see Box 1).

Box 1 – supporting the structure

"Clear, concise and fast to access information."

"I think this was a long due need for simplicity and clarity."

"Language used is much easier to understand and more simply put better clarity, more concise, less bloated."

"More succinct and reader friendly."

"I feel that this is a far most sensible and comprehensive layout. It makes it easier for the layperson to understand."

18. The 10 respondents that did not support the structure of the proposed OPS focussed on the language still being too complicated and jargonistic, despite the revisions along with questions as to whether the OPS can be used to measure impact (see Box 2)

Box 2 – not supporting the structure

"They are far too complicated, contain too much jargon and management speak. This make it almost unreadable for anyone over 50. The whole lot makes me want to retire early."

"There is no evidence to support the Osteopathic Practice Standards, that they actually have any impact on the standards of Osteopathy today."

Question 2: Accessibility and wording of the standards and guidance in the updated *Osteopathic Practice Standards*

19. In the updated *Osteopathic Practice Standards*, the aim is to reduce areas of repetition and possible ambiguity. Some standards have been deleted, where their intent is felt to be sufficiently covered elsewhere, or combined with others standards to avoid repetition or to clarify their meaning. Some standards have been moved from one theme to another (for example, from Safety and quality in practice to Communication and patient partnership, or from Professionalism to Safety and quality in practice'), where this seemed appropriate. The language throughout was reviewed in an attempt to improve clarity and to support the implementation of the standards in practice. This question related to this process, and asks whether the updated standards are accessible and clearly worded.

2. Do you feel that the content of the standards and guidance in the updated OPS is accessible and clearly worded?	Yes	No
Response rate	**103**	**23**

20. Responses to this question were typical of those seen in response to question 1 around clarity, user friendly layout and use of simplified language (see Box 3).

Box 3 – Updated OPS is accessible and clearly worded

"Very clear and detailed and some areas have been broken down into sub sections to offer further clarity and to avoid the vagueness that some points had in earlier standards e.g. Q4 being broken down into Q4 and Q5 to D3 (duty of candour) and D4 (complaints) separating the issues has allowed for more clarity in each respective case earlier it was a vague explanation which could lead to misinterpretation."

"Yes it's very clear and easy to read and understand."

"Language, layout and general structure is much easier to understand."

21. A number pointed out that the document needed an initial summary/introductory page, which wasn't included in the draft document but will feature in the final version.

22. Slightly more commented than in the previous question (on the structure of the updated OPS) that the content and guidance was not accessible and clearly worded (see Box 4).

Box 4 – Updated OPS not accessible and clearly worded

"There is still a lot of repetition."

"I think there are areas of slightly conflicting wording."

"No. I would welcome more interactive seminars arranged by the regulator, so as to have meaningful discussions in groups."

"There is not enough about risk. There should be absolute clarity about what we should be telling our clients and a new OPS was a chance to help on this."

"It's still not written in accessible plain English. Needs further revision please using simpler language."

"Ambiguity and poor choice of language e.g. patient ?rights? what is meant here?"

Reference made to specific standards or guidance

23. One respondent made a particular point regarding A3.1.1, concerning informing patients of their right to have a chaperone:

    "This has not been updated and appears to imply that osteopaths must explicitly inform each new patient about their right to have a chaperone before examination. In my experience in PCC hearings and expert report writing, this is not reflective of normal osteopathic practice. It is also my experience that the PCC has never made a finding that that a registrant has failed to offer a chaperone; I question why such an explicit obligation appears and yet not enforced? It also appears to be contradicted by A6.5 which lists patients who must have a chaperone offered to them; the corollary being that as most patients do not fit the criteria of 5.1-5.4, there is no requirement to have a chaperone offered. I think this update should be used as an opportunity to conflate A2-1-1.1 and A6-5 and to offer clearer guidance about the obligations an osteopath has with regards to offering a chaperone to patients."

24. It was also questioned whether the term 'material and significant risk', which features in A3.2, should also be used instead of the term 'benefits and risks' in A4.6.

Question 3: Guidance relating to standard A4 regarding consent

25. In the updated *Osteopathic Practice Standards,* some of the more detailed content within the guidance regarding the treatment of children, has been removed in an attempt to focus the guidance on key issues. Subheadings have been added to the guidance for to improve navigability.

3. In relation to standard A4 is the guidance sufficient to support the implementation of the standard?	**Yes**	**No**
Response rate	**95**	**19**

26. The majority supporting the standard A4 guidance did not add further comment. Where respondents did comment it was felt that the guidance was more focused and meaningful in practice (see Box 5).

Box 5 – Supporting updated A4 and guidance

"the previous consent guidance was much too woolly, and on first viewing appears to be much clearer."

"I appreciate the nod to consent and the treat as you examine approach."

"the fact now we have consent guidance is more appropriate and makes the standard with the guidance more focused."

"The requirement to undertake CPD in the field of communication and consent should make the consenting of a patient more meaningful."

Reference made to further enhancements

27. Respondents suggesting further enhancements concerning Standard 4 were focussed around 4 key areas: (1) paediatric treatment, (2) Montgomery Judgement and risk, (3) process of gaining consent and (4) recording consent (Box 6):

Box 6 – suggesting further enhancements

Paediatric treatment
"Point 15 could benefit from being enhanced. Agree that should involve a person with parental responsibility for the child when seeking consent, however is there a need to state more clearly the scenario where there is potential for conflict i.e. where there is a mature child who is well capable of making informed decisions and giving consent disagrees with their parents views/decisions." *"Most of this is clear with the exception of Treatment of children and young people. Having read the draft I would say it is unclear what the legal requirements are for osteopaths gaining consent to treat children of 16 years and less, and for treating young people 16-17 years……The draft clearly indicates that consent in this area is complex but does not give adequate guidance regarding the law. I am rather confused now about this issue."*
Montgomery judgment 2015 and risk
"All risks and contraindications to treatment and examination have been explained." A case of highlighting the importance of listing risks which might be helpful would be by naming the Montgomery case." *"The relevance of Montgomery and its implications were very well explained in*

the Royal College of surgeons guidelines including the use of an example/role play. This may be useful alongside guidelines to better explain why changes have occurred in consent law."
Process of gaining consent
"Whilst the guidance is very detailed, there is an over riding impression that every manoeuvre, touch, expression needs to be consented for, and seems overly onerous especially with reference to A4.2……." *"I find the continual requirement to obtain consent from grown up otherwise healthy and able persons on who have 'chosen' to pay to see me intrusive in practice....you simply can not keep asking patients for their permission again and again……repeating the consent and risk mantra puts patients on guard and I believe leaves them feeling more at risk."*
Recording consent
"I would be interested in how we should record consent, what is the minimum we should record as this is open."

28. Of those responding that the guidance for Standard A4 was not sufficient, comments focussed on four broad themes: (1) Use of language, (2) valid consent – what it is, and whether GOsC can be more prescriptive (3) recording of consent and (4) patients changing their decisions (see Box 7).

Box 7 – A4 guidance not sufficient

Use of language
"General point raised around language and use of must/ should – seems very muddled and suggest must = standard and should = guidance" *"If there are things that we MUST do legally then this should be made clear, as this is a requirement and not guidance. I would be interested in how we should record consent, what is the minimum we should record as this is open."* *"Does saying 'must' in the guidance, effectively made it a standard."* *"consent needs to embrace implied consent, verbal consent, written consent."* *"… consistent use of the term 'material and significant risk' at A4-6 is needed. More guidance on what this term means is also needed as it is a legal term that osteopaths may not fully comprehend."*

"A4-20; consider reintroducing intra-oral techniques as an approach requiring written consent. This will then be consistent with the notion that all body-cavity assessments and/or treatments require written consent."

What is valid consent – GOsC should be more prescriptive on this?

"I know that obtaining consent is a very difficult area, despite your implications that if certain procedures are followed it isn't. However, you always seem to put too much emphasis on what is NOT valid consent, compared to committing to what IS."

"different osteopaths will have different standards regarding expectations regarding a practitioner explaining nature, purpose, benefits and risks of the examination or treatment proposed and recording information discussed, patient concerns, expectations or requests for information…….. I think the GOsC should provide examples of what they expect / require so there are guidelines."

"A4-19; rephrase to describe or give examples how the element of voluntariness can be captured; currently the description is not helpful and simply warns of the effect of non-voluntariness on consent. Provide examples of how this behaviour IS captured in the consent and case record rather than how it is NOT, which is the current situation."

"A4.6 what is a suitable length of time for the patient ' to reflect on what you have proposed'. we feel this should be removed or clarified."

more explanation and emphasis could be given around the term 'ongoing'; consent must never be assumed and must be a continual dialogue throughout the course of the treatment, which maybe over several sessions and include differing treatments."

Recording of consent

"If as a practitioner you always have an introduction before the case history that includes an agreement with the patient that you will stop treatment if they are not happy with it, does it have to been written down specifically in the records that you have covered this?"

"it is unclear in terms of what osteopaths would be required to record, if we have to record everything, there wouldn't be time for treatment."

Patients changing their decisions
"osteopaths are vulnerable when they have sought consent (for a particular technique, for example), but the patient did not remember and later denied this." *"….patients might change their mind after the event and deny having given consent. How does the guidance help in such scenarios?"*

29. As an extension of the discussion on consent, one of the respondents further criticised the guidance to A6 regarding respecting patients' dignity and modesty, feeling that section 2 was too prescriptive, and that section 1 was enough.

Special interest groups

30. Representatives of the Osteopathic Sports Care Association (OSCA) asked what would be considered implied consent in the context of pitch-side intervention or treatment. They also pointed out that in children's sport, parents will often sign a form of consent allowing a medical team to intervene where this is felt to be necessary. One of their interventions may be to remove someone from the field of play if they felt that they had experienced a concussion, for example. The player may not consent to this, and may lobby to stay in play.

Question 4: Osteopathic philosophy and principles

31. The current standard B1 states; 'You must understand osteopathic concepts and principles, and apply them critically to patient care'. This drew some critique within responses to the 2016 call for evidence with respondents stating that osteopathic principles are subjectively interpreted and therefore not universally agreed, understood or applied, nor unique to osteopathy. Feedback suggested that therefore it was difficult to justify their inclusion in a 'standard' which summarises principles that apply to all osteopaths.

32. However, reference to osteopathic principles or philosophy is an important issue for some osteopaths. Many consider these as central to their osteopathic identity and practice, although 'philosophy' is not mentioned within the current *Osteopathic Practice Standards*. For some osteopaths and osteopathic groups, osteopathic philosophy provides the foundation from which osteopathic principles derive. Osteopathy is patient-centred, rather than condition or disease centred, with predisposing factors, maintaining factors and consideration of the body as a whole being a basis for osteopathic care, and many see the principles as the way that this is implemented in practice.

33. The issue is, given the universal nature of the standards, and the more explanatory nature of the guidance, whether reference to osteopathic principles or philosophy should be contained within standards or guidance, or even

referenced at all. Osteopathic principles and philosophy are owned and defined by the profession, not the regulator.

34. In the consultation respondents were asked to give a preference out of three options for addressing this issue:

    Option 1: Inclusion of the osteopathic philosophy and principles in a standard

    Option 2: Inclusion of the osteopathic philosophy and principles in guidance (rather than standards)

    Option 3: Removal of osteopathic philosophy and principles from standards and guidance

35. Option 2 is the GOsC suggested version as it is felt this represents a balanced approach between both the importance of the osteopathic philosophy and principles and the fact that they are not universally agreed or applied in the profession.

36. We have referenced osteopathic philosophy and principles within the guidance to standard B1 (*You must have sufficient and appropriate knowledge to support your work as an osteopath*). This now includes a statement that this knowledge should include '*An understanding of osteopathic philosophy, principles and concepts of health, illness and disease, and the ability to critically apply this knowledge in the care of patients'.*

37. This was one of the two questions (the other being question 8 regarding standard C6) which drew the largest response. The Osteopathic Alliance (formed of osteopathic professional development colleges and special interest groups) are strongly in favour of Option 1, and lobbied its member organisations to respond to this particular question, suggesting a form of words which was reflected in many of the emails and website responses received:

4. What is your preferred option for referencing osteopathic philosophy and principles?	**Option 1 Principles and philosophy as standard**	**Option 2 Principles and philosophy as guidance**	**Option 3 No mention of principles or philosophy in guidance or standards**
Responses rate	**243**	**45**	**8**

38. Table 2 gives examples of comments made in favour of option 1 and option 3, which are in marked contrast. Table 3 shows comments made by some who felt that option 2 provided a more pragmatic approach.

39. A point of discussion which emerged with an osteopathic educator was around the reference to principles in the context of internationally qualified applicants

applying to join the register. Would moving this reference to guidance diminish the need for these applicants to demonstrate a through knowledge of osteopathy?

Table 2 – Question 4: What is your preferred option for referencing osteopathic philosophy and principles?

Option 1 **Principles and philosophy referenced within a standard**	**Option 3** **No mention of principles or philosophy in guidance or standards**
"Osteopathic philosophy and principles should be a Standard, not downgraded to Guidance." (76 email responses used this exact wording). *"Principals define the profession. Without it, the public will think we offer little more than manual therapy, which is not the case."* *"Our principles are what makes osteopathy osteopathy. Whilst many do not practise in accordance with the principles, it remains an aim to which all should aspire'* *"This will continue to maintain a presumption that osteopathic practice is based on established principles which are unique to the profession and not simply another branch of manual therapy."* *"……. Surely it is impossible for someone to call themselves an osteopath if osteopathic principles and philosophy are not central to their practice and identity? Why are you allowing this?"* *"Because the osteopathic principles are what differentiate us from all of the body health practitioners out there. They're what make us effective and safe and able to tackle problems that many*	*"Osteopathic principles and philosophy is out of date concepts, medicine and osteopathy has moved on from these historic non scientific theories."* *"There are no 'osteopathic principles', there are only principles of good healthcare, which should be personal-centred and evidence based."* *"Other health professions now use evidence based clinical guidelines to help to inform their practice but the osteopathic profession has, until now, chosen to stick doggedly with an archaic set of 'principles'. These principles are often imbued, it seems to me, with a kind of quasi-religious significance. …… it is obvious that osteopathic principles are vague platitudes that cannot possibly be a very useful guide the day to day decision-making and behaviour of clinicians……..there is absolutely nothing uniquely 'osteopathic' about them in any case. Therefore, they cannot possibly be 'central to the identity' of osteopaths or osteopathy."* *"Because I don't believe in dogma and want a "profession" that is looking forward not backward."* *"There is no 'philosophy' of osteopathy; merely a series of dogmatic statements which do not stand up to scientific or*

are unsure of how to deal with." *"Those who deny the inclusion of osteopathic principles in their practice could be accused of not practising osteopathy at all."* *"The absence of osteopathic philosophy and principles as a Standard will facilitate the demise of the profession and those that stay in the profession will never know what Osteopathy is. This is so important to the future of the profession. It HAS to be a required Standard."* *"….Osteopathic Philosophy and Principles is the basis of what we do, therefore, without it we would lose our discrete identity. We feel very strongly that it should be maintained as a standard."* *"……Osteopaths will only interpret these words as they know how and will relate to them in their own context, so all views are honoured. No-one is asking anyone to interpret in a dogmatic way. There is risk to patient safety, a loss of osteopathic identity and development, in not including it for the reasons above."*	*academic scrutiny. its time these were dropped from professional regulations as it undermines the seriousness of the organisation. Critics and skeptics question professional osteopathic identity and regulation when it remains based in these anachronistic notions."* *"Enshrining poorly defined principles hinders progress and is not the job of the regulator."*

Table 3 – Option 2 responses

Option 2 **Principles and philosophy as guidance (as suggested within the draft under consultation)**
"It seems a reasonable compromise." *"It allows for more flexibility in our thinking."* *"Option 2 makes more sense to me. I like to be guided rather than told what to do."*

"It is not as limiting to the potentially more 'modern' osteopath who doesn't feel defined by the possibly outdated osteopathic principles. It allows us to navigate freely through our own interpretation of what we as individual practitioners believe osteopathy to be to us."

"Difficult to fully define osteopathy for standards - more flexible in guidance."

"Difficult to have a standard when osteopaths themselves can not agree on the principles."

"I think this gives the maximum flexibility in the treatment and variety of different ways that osteopaths work."

"Different osteopaths bring their own experiences and thought process to this area, it would therefore be difficult/impossible to enforce as a standard."

"The iO supports option 2. This is a balanced approach allowing for a degree of flexibility in individual belief and interpretation whilst maintaining the overall ethos. The phraseology is acceptable."

Question 5: Standard B4 and its supporting guidance

40. Standard D3 in the current *Osteopathic Practice Standards* states: 'You must be capable of retrieving, processing and analysing information as necessary'. Feedback indicated that this was not always well understood. In the updated standards, this is modified to '*You must be able to analyse and reflect upon information related to your practice in order to enhance patient care'*, and becomes B4 under 'Knowledge, skills and performance'. The question relates to this modification and its supporting guidance.

5. Is the updated standard B4 and its supporting guidance sufficiently clear and easy to use	**Yes**	**No**
Response rate	**116**	**15**

41. The majority of those that thought the updated standard B4 and its supporting guidance were sufficiently clear and easy to use commented that the guidance was comprehensive and well thought out (see Box 8).

Box 8 – B4 and its guidance are clear and easy to use

> *"This is phrased well to reflect the concept of Evidence Informed practice."*
>
> *"Generally sound as presented."*
>
> *"B4 guidance seems comprehensive."*
>
> *"Open to interpretation, but agree to the principle."*

42. Those that did not feel the updated standard B4 and its supporting guidance were sufficiently clear and easy to use generally commented that the standard and its guidance are still unclear, and they are not sure how this should be implemented (see Box 9).

Box 9 – B4 and its guidance not sufficiently clear

> *"We* [a local osteopathic group]*don't feel this is clear enough - what is expected? Feedback form analysis or auditing etc?"*
>
> *"I think the concepts of retrieval and processing are important and would prefer them to be retained in some way within the wording of the standard."*
>
> *"This could be seen to require generalised research on patient data, or require reflecting eg on a particular case. It is not clear to me what it is you expect an osteopath to specifically be able to do. I am not sure what 'related to your practice' specifically means. It could mean anything and everything that occurs or potentially impacts on your practice."*
>
> *"Doesn't seem any clearer than previous standard, just different words. What exactly are we being asked to do? What information is to be analysed, for what purpose and for who? If an audit is to be mandatory, say so and about what and for whose benefit is the information for, is it to submitted or published at all?"*

Question 6: Standard C2 and its guidance for recording patient information?

43. The current standard C8 requires that osteopaths ensure that their patient records are full, accurate and completed promptly. This standard becomes C2 in the proposed updated *Osteopathic Practice Standards*. The guidance has been edited to enhance clarity, and an additional reference made to recording the presence, status and identity of any observer, as well as the patient's consent to their presence. The question relates to these revisions.

6. Is the updated standard C2 and its guidance clear and easy to use in relation to the recording of patient information?	Yes	No
Response rate	**127**	**6**

44. Those that considered the updated standard C2 and its guidance to be clear and easy to use in relation to the recording of patient information commented on the greater clarity the updated standard provided (see Box 10).

Box 10 – C2 and its guidance clear and easy to use

"All seems clear and concise."

"It isn't possible to fully list each requirement for record keeping, but the new wording makes it more explicit and the additions allude to other implicit requirements."

"C2 1.16 I think stating that notes should be completed on the same day gives greater clarity of an area that often caused great discussion about what 'contemporaneous' meant."

45. Of those that thought the updated standard C2 and its guidance were not clear and easy to use in relation to the recording of patient information, one asked for a further definition, whilst, another suggested a reformatting of the guidance (see Box 11).

Box 11 – C2 and its guidance not clear

"define full and promptly".

"these appear to be in a sequence following a patient encounter, therefore 1.8 'records of consent' should appear after 1.4. and 1.14 should mention the word chaperone and appear after 1.1. making it consistent with the sequence implied at A3 1.1."

Question 7: standard C3

46. Current standard D2 states; 'You must respond effectively to requests for the production of high-quality written material and data'. Feedback indicated that

this standard and its guidance were not clearly understood. It is suggested that this standard would be better placed within the Safety and quality theme, and linked to the keeping of records. This has been included in a slightly reworded form as a new C3, with modified guidance to refer to the production of reports and information to support patient care and effective practice management. The question relates to these modifications.

7. Is the updated standard C3 sufficiently clear and easy to use?	**Yes**	**No**
Responses via website and consultation form	**105**	**10**

47. Additional comments made by those respondents that felt the updated standard C3 was sufficiently clear and easy to use were limited. One respondent commented on the circumstances in which such material may need to be produced (see Box 12).

Box 12 – C3 clear, but further suggestion offered

"Examples of the circumstances in which these items may need to be produced would be helpful, to avoid disclosures which may be deemed to threaten patient confidentiality. The need for the patient's written consent to disclose written material and data should be included, or a direct reference to new standard D5 provided."

48. For those that did not feel that the updated standard C3 was sufficiently clear and easy to use further clarity was of paramount importance, as was wording (see Box 13).

Box 13 – C3 not clear

"Respond effectively? Explain that. What is effective? By whose standard is it judged? Define 'High Quality'... again by whose standards?"

"Specificity is important. It is too generalistic. Where are the pro-forms, then? What is considered appropriate format?"

"Comparing C.3.1 and C.3.2 illustrates a recurring theme in this draft. C.3.1 only states I need to be 'able', with nothing about whether I actually demonstrate that I do or not, or what happens if I don't. C.3.2 on the other hand finally specifies something I MUST do - i.e. 'develop mechanisms', not 'be

able to develop mechanisms'. The variability of the implied standards induces stress over how to comply with them, which in turn tends to lead to them being ignored as 'too difficult'."

Question 8: Standard C6 and the position of osteopathy in relation to the promotion of public health?

49. Current standard D11 states; 'Be aware of your role as a healthcare provider to promote public health'. Feedback indicated that the context of this standard could be clearer. In the updated *Osteopathic Practice Standards*, this becomes standard C6 under the 'Safety and quality in practice' theme. The suggestion is to modify the guidance to: '*You should be aware of public health issues and concerns, and be able to discuss these impartially with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these*.' The question related to the updated guidance.

Do you feel that the updated guidance to standard C6 is clear and adequately sets out the appropriate position of osteopathy in relation to the promotion of public health?	**No**	**Yes**
Response rate	**234**	**61**

50. This question drew a significant response, with a large number of respondents objecting not to the updated guidance, but to the standard itself, specifically, the requirement to 'promote public health'. The Osteopathic Alliance, again, lobbied their member organisations to respond to this question, suggesting wording which was used by a large number of respondents (see Box 14).

Box 14 – Not accepting C6 in relation to promotion of public health

"I do not accept Standard C6: 'Be aware of your role as a healthcare provider to promote public health'. I propose: 'Be aware of your role as a healthcare provider with regard to public health'." (76 email responses used this exact wording)

"I do not accept Standard C6: 'Be aware of your role as a healthcare provider to promote public health'. I propose: 'Support patient care through an awareness of public health issues'."

"The text supporting this standard is fine ("You should be aware of public health

issues and concerns, and be able to discuss these impartially with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these"). However, I disagree with the wording of the standard itself."

"Not a problem to support public health initiatives, but I have concerns that we could be seen to have to actively promote all aspects of public health with the current wording."

"Reference should be made to the uniquely osteopathic standpoint of healthcare based on facilitating good health (salutogenesis) rather than purely symptomatic alleviation."

"There are many public health concerns and I do not have a problem with promoting weight, osteoporosis, vit D, smoking etc but I feel that the phrase could include ones that would not occur to us to mention or know enough about, as such I think this standard is not specific enough."

"It is important that our role as osteopaths is to be aware of public health issues and support our patients to make better and more informed choices. It is not to be forced by law to endorse public health choice's that contradict our osteopathic philosophy and principles."

"We unanimously felt this was extremely dangerous ground. Unreasonable expectations of Osteopaths. What would the definition of 'Public Health issues' be? Would it be bird flu, nutrition, measles..." If the regulator expects this level of knowledge then surely the Regulator needs to give regular guidance notes and public health bulletins? Most of us only know as much as the general public relating to any health issues-in terms of what is on the news or on the TV."

"C6 should be dropped entirely. We do not have a "role in promoting public health". It's not why I became an osteopath. It is one small step away from being forced to deliver government policy."

"I do not wish to be considered a healthcare provider promoting public health. Happy to help patients modify their lifestyle/exercise/nutrition possibly."

From the Institute of Osteopathy:

"We strongly recommend that the language of the standard should be revised to make it clear that it refers to promoting the health of the public and ensure that it cannot under any circumstances be interpreted as a blanket requirement to promote public health policy. Based on the NMC's standards for competence for professional midwives, we suggest the following alternate form of words:

C.6 Be aware of your role as a healthcare provider to contribute to enhancing the health and social wellbeing of your patients.

The guidance under this standard is also slightly unclear. Requiring osteopaths to 'be aware of public health issues and concerns' without further qualification could be taken to imply that osteopaths should be aware of any and all public health issues and concerns. This is clearly not practicable. We therefore suggest that this should be amended to: *'be aware of public health issues and concerns that are relevant to your practice…'*
Notes from patient focus group:
Some felt the term 'public health' was too vague, and queried the balance between the health of the broader community, and their own individual health as patients. Some had experienced osteopathic treatment consistent with the guidance to this standard, with their osteopath providing advice or signposting resources around weight loss, for example. Some felt that the word 'promote' in the standard limited the autonomy of the osteopath in this respect, and suggested 'support' or 'encourage' instead. Some said that they did not see this aspect as the role of their osteopath, and that if they wanted public health advice, they would go to their GP
Regional group meeting:
'… the public health matter was the one that generated the most discussion. The group were broadly happy with it once they understood the guidance - but wondered if 'balanced' should replace 'impartial' in the guidance.'

51. Some respondents were supportive of the suggested wording for Standard C6 (see Box 15).

Box 15 – Supportive of C6 and its guidance

"I feel the GOsC wording is fine. Surely we can all choose HOW we promote general public health?" *"Yes - however adding some subheadings or points maybe useful for what is considered promotion of public health and osteopathy."*

Question 9: standard D2 and its supporting guidance - boundaries

52. D16 of the current *Osteopathic Practice Standards* states 'do not abuse your professional standing'. The guidance to this focuses largely on maintaining sexual boundaries with patients. The standard has been updated (now D2) to

specifically require osteopaths to establish and maintain clear professional boundaries with patients, and not to abuse their professional standing and position of trust, and the guidance has been expanded. The question relates to these changes.

Is the updated standard D2 and its supporting guidance sufficiently clear and easy to use?	**Yes**	**No**	**No Yes/No answer given**
Response rate	**114**	**15**	**3**

53. Those that supported the updated standard D2 and its guidance thought that was more explicit and well worded (see Box 16).

Box 16 – D2 and its guidance clear and easy to use

"Clear and easy to use."

"Again, this is better and much more explicit."

"Excellent wording. This is much clearer now and no further changes is needed."

"This is an improvement and is clear."

54. Those that did not feel that the updated standard D2 and its guidance were sufficiently clear and easy to use, offered more comment. Some queried the new guidance paragraph 5.7 – 'you must not end a professional relationship with a patient solely to pursue a personal relationship with them'. Others raised issues around the wording of the guidance or wanted more clarity (see Box 17).

Box 17 – D2 and its guidance not clear and easy to use

"the requirement "You must not end a professional relationship with a patient solely to pursue a personal relationship with them" seems unreasonable. I had understood that, should an osteopath wish to develop further a personal relationship with a patient, then they were expected to cease treating that patient in order that the possibility of a closer personal relationship might be explored by mutual consent."

"I believe it would be wise to state that the therapeutic relationship must be terminated if the two people concerned are interested in pursuing a personal relationship - they could end up getting married for example. It does not necessarily have to be a sordid matter……."

"This is essentially meaningless again - because it would never be 'solely' - since such an intention would stem from and already impracticable therapeutic relationship, as previous clauses make some attempt to codify."

[Re D2.5.6]"The basic points were, the wording 'must not' which was thought to be completely inappropriate and disproportionate given the subsequent guidance acknowledging that in small communities relationships may well develop…"

"We need more clarity. Friendships do ensue we need to be clear about when it is ok. and of course existing friends become patients. So this needs to be taking into consideration in the standards. If you work in a particularly speciality say performing arts medicine or sports then the osteopath possibly performs with them or plays in matches so it is impossible not to make friend."

"I found the structure and wording of D2 confusing. It would have been helpful to have more guidance on what is considered professional boundaries when as osteopaths we treat people of our community including colleagues and friends."

*…."*not much about professional commercial and business relationships being formed, for example , engaging patients in a commercial capacity - how does that impact practice?"

Patient focus group:

"…….. *that the guidance covered all eventualities, but this is a complex area."*

"D2.3 might be better separated into two points, to avoid it seeming that only vulnerable patients should be protected."

Question 10: standard D3 - the duty of candour

55. D7 of the current *Osteopathic Practice Standards* state that osteopaths 'must be open and honest when dealing with patients and colleagues and respond quickly to complaints'. In the proposed revised standards this has been divided this into two revised standards (D3 and D4) – dealing separately with the duty of candour and the managing of complaints. D3 now refers specifically to the duty of candour, and the related guidance reflects the joint statement on candour, signed by the Chief Executives of all UK healthcare regulators. The question relates to these changes.

10. Is the updated standard D3 and its guidance in relation to the duty of candour sufficiently	**Yes**	**No**	**Yes/No not indicated**

clear and easy to use?			
Responses via website and consultation form	**113**	**9**	**3**

56. There were a number of positive and supportive comments made, for the support **for** the updated standard D3 and its guidance in relation to the duty of candour (see Box 18).

Box 18 – D3 and its guidance clear and easy to use

"I am happy - no changes to suggest."

"Good to divide into two revised standards."

"You have a duty of candour to fulfill, that is to be completely open and honest with patients."

"Very clear"

"D7 was very vague but separating both issues has made each one more detailed and has clarified each issue to a much greater extent."

57. Some queried the balance between candour and the admission of liability (see Box 19).

Box 19 – balancing candour with admissions of liability

"Perhaps address concern of candour vs. liability insurance?"

"Apology? Our insurers specifically advise against the use of apology. in fact most don't allow a normal human response! which is probably why litigation is taking off as it is!!"

"Difficult to balance this with informing insurer etc"

58. The admission of liability and candour was an issue that was also mentioned by the patient group that the phrasing of paragraph 1 of the guidance could be phrased in a way that did not imply blame – some felt that 'goes wrong' was not quite right, as things can go awry without it being the osteopaths fault. It was queried whether the intent was 'if you feel you've done the wrong thing'.

59. In relation to D3 one respondent pointed out that the words 'if appropriate' at the beginning of para 2 of the guidance give the impression that it might be appropriate not to be open with colleagues and employers. It was suggested these words be removed so that it better reflected the joint statement on candour.

Question 11: standard D5 and maintenance of patient information

60. Current standard D6 regarding respecting patients' rights to privacy and confidentiality has been expanded in an amended D5 in the updated standards to also require osteopaths to effectively maintain and protect patient information.

11. Is the updated standard D5 and its guidance sufficiently clear and easy to use in relation to the maintenance of patient information?	**Yes**	**No**
Responses via website and consultation form	**118**	**8**

61. A few respondents highlighted their approval of standard D5 and guidance:

Box 20 – D5 and its guidance clear and easy to use

"Satisfactory from my perspective."

"Again breaking D6 down into sub sections has allowed for more information and therefore more clarification and has narrowed the margin down for vagueness which the previous standard had."

62. Some who thought the updated standard D5 and its guidance were not sufficiently clear and easy to use, made comments around some specific aspects of the guidance, (see Box 21).

Box 21 – D5 and its guidance not clear and easy to use

"The requirement to inform every patient / parent of your policy regarding retention, transfer and disposal of records which should include whether it is your practice to retain them beyond eight years, or, in the case of a child, beyond their 25th birthday seems overly onerous. I am unaware of my GP, optician or dentist being required to do this."

"D5.5 the practicality of maintaining practice records after death or if moving away after retirement is very difficult to do practically."

"I wonder if D5.2 should emphasise 'without charge' as this is the requirement of the GDPR."

"D5.3 and 4 - The implication of osteopaths keeping records longer than 8 years - could this be considered unnecessary retention of data under GDPR??"

"When an osteopath refers a patient back to their G.P., do you really think that the osteopath should tell the G.P> to respect the patient's confidentiality. When one medical professional communicates with another, this is UNDERSTOOD !"

"Here and elsewhere that a 'policy' is required, assuming they're to be written, shouldn't there be a definitive list of required practice policies, with the GOsC to provide approved pro-formas for a 'policy binder', which could be produced when required?"

"I found some aspects of D5 unclear and would have liked more practical guidance. Do we need to inform patients when their records are being destroyed after 8 years? or is it if we are keeping them after 8 years? Also what are the practical steps we are supposed to take in regards to informing patients when selling our practice?"

"Clear and explicit. However add somewhere into 8 when there is a child protection issue as one of the few times when you can disclose information"

"D.5.6: Specify that the Data Protection Act requires informed voluntary consent to use client data for research, and appropriate safeguards for electronic storage to prevent security breaches."

"D.5.7 - "(or someone on their behalf)" - need to specify who this might be, and under what circumstances their consent is sufficient to replace that of the patient, particularly if this might conflict."

"D.5 - 7.5 - "disclose only the information you need to, for example, does the recipient need to see the patient's entire medical history, or their address, or other information which identifies them?" - fine, but what if this conflicts with prior contractual obligations - e.g. such as those with AXA-PPP and BUPA, who require full access to the complete patient records?"

*"Could add 'safely **and securely**' in point 5 to assure confidence in the procedure after a death."*

From a consultation meeting:

One slight concern was around the new CPD and case based discussions. Should we have a line in there that says we need to get patients consent – we need to

be careful that in suggesting case based discussions are a useful way of gaining objective feedback, osteopaths don't inadvertently breach confidentiality, as even anonymised cases may be identifiable, particularly in small communities.

Question 12: standard D10 and the position of osteopathy in relation to other healthcare providers?

63. In relation to current standard D1 (You must consider the contributions of other healthcare professionals to ensure best patient care) feedback from the 2016 call to evidence indicated that this, and its guidance were not always clearly understood. This standard becomes D10 in the proposed draft revised *Osteopathic Practice Standards*, and its guidance has been modified slightly to emphasise an understanding of the contribution of osteopathy within the context of healthcare as a whole, and a collaborative approach to care, where appropriate. The aim is to emphasise that osteopaths are part of a larger community of healthcare professionals, and to reflect a respectful and collaborative approach with the patient at the centre. The question relates to these modifications.

12. Do you feel that the updated guidance to standard D10 is clear and adequately sets out the appropriate position of osteopathy in relation to other healthcare providers?	**Yes**	**No**	**Unsure**
Response rate	**110**	**10**	**1**

64. Whilst supporting this standard, some respondents to this question made comments around the views of other healthcare professionals towards osteopaths, and one queried what 'other healthcare providers' included? (see Box 21).

Box 21 – osteopaths in relation to other healthcare providers

"I agree completely AND follow this rule. I do know for a fact that other health practitioners (recent examples coming from chiros and physios via a patient) do NOT adhere to this idea of mutual respect."

"While we must be aware of other elements of the healthcare environment, all too often, others are not so respectful of us."

"Ideally, you should specify what constitutes 'other health and care professionals'

- e.g. only regulated?"

65. Some felt D10.2 in the guidance to this standard required more clarification, and one respondent queried whether further guidance was needed around the management of differences of opinion (see Box 22).

Box 22 – D10 guidance not clear

"D.10.2 - "Understand the contribution of osteopathy within the context of healthcare as a whole." - honestly, who 'understands' that? Maybe 'have an appreciation of' - but what does it really mean, and how would you evaluate that? How would you demonstrate someone didn't, and against what standard?"

"Is there a need to mention what to do if there is conflict of opinion between the views/treatment proposals of the other health and care professional and the osteopath or vice versa."

Question 13: anything missing from the document?

66. This was a straightforward question as to whether anything was missing from the document.

13. In your opinion is there anything missing from the document?	**Yes**	**No**	**Unsure**
Response rate	**25**	**90**	**1**

65. Some respondents highlighted areas which they felt were missing, or could be enhanced. These related predominantly around the themes of clarification/further information, osteopathic identity and working arrangements/business practices (see Box 23).

Box 23 – Elements missing from the document

Clarification/further information

"…there is a need for clarity in the use of adjectives and adverbs, as these are open to interpretation, Especially since the interpretation will come from the GoSC, as it imposes the standards."

"What about Good Samaritan Acts. When you are at a sports event or a

performance event and one of the sports men or performers has an accident and you go to assist. It has happened to me. I asked for clarification from the IO but the answer was so woolly to be useless. As a qualified first aider I can not remove my osteopathic knowledge when going to assist someone …"

"I recognise that it is impossible to exhaustively list any and all guidance regarding children (and other vulnerable populations). However, I would very much like to see some explicit pointers to guidance, perhaps from external bodies, particularly regarding safeguarding, reporting, current issues such as FGM [forced genital mutilation] and modern slavery, and so on."

"I still don't like the ambiguity around 'what I must do' and 'what I should do'. I see what you're going for, but you leave all the burden of adequate compliance with the practitioner. At worst, if I have a dispute with you, you can interpret the vagueness to mean pretty much what suits you, and from experience I know that is what you tend to do….."

"If you are the people charged with telling me to 'Jump', I think I can reasonably ask 'how high?', and I do not want to hear 'As high as you as a professional think we as the protectors of the public would reasonably expect of you'."

"Where would I find information on how patients would have access to their records after my death? Also where would patients' records be stored?"

"B.1, 1.5 the awareness of principles and applications of scientific enquiry...In my view I don't think this is as clear as it could be. As I suggestion something on the lines of 'an understanding to support and promote evidence based practice.'"

"Possibly in Standard D.6 there should be specific inclusion of detail regarding respect for others beliefs which may impact on how you work with them in a treatment - I am thinking as an example, Sikhs who wear turbans - as opposed to purely legal requirements."

"Care over social media."

"There's nothing about risk at all. It's an absolute scandal that we have nothing concrete to go on with this although its been an issue for years now. It's an exercise in obfuscation designed it seems to purposely snare the unwary osteo."

Osteopathic identity

"To preface the whole document that as well as providing a benchmark to protect the public a clear statement that the document upholds the uniqueness of osteopathy as a profession and encompasses osteopathic principles and practice."

"The option to have a clear regard to osteopathic principles and philosophy when

interpreting public health policy for individual patients, as osteopathic philosophy and principles may at times be at odds with public health policy, is missing from this standard." *"The regulation should protect the current free thinking and practicing as an osteopath and not create limitations and forcing us to become any way or form government mouth peace…."* *"What is our role as 'Osteopaths' going to be going forward are we going to be completely integrated into the general medical model? or can we take a half step back and say some of us actually like being alternative practitioners, tolerated being complementary and ancillary but draw the line at becoming manual therapists within the medical model."*
Working arrangements/business practices
"There is some confusion as to the level of responsibility an Osteopath has when another Osteopath works out of their premises (, manages their own lists and bookings etc.) but is ultimately self-employed .The insurers now ask this question and it would seem that some have been told that if a colleague has a complaint against them then the practice could be litigated against?" *"What are we responsible for regarding other practitioners in our practices - osteopathic and other?"* *"Guidance on professional conduct regarding referral of patients regarding locuming. I have lost countless patients who have not been transferred back after my absence from the practice, either from illness or holiday….."*

Question 14: Suggestions

14. Are there any suggestions you can make which you feel would improve the clarity of the document?	**Yes**	**No**	**No 'yes/no' answer**
Response rate	**24**	**83**	**4**

66. Suggestions offered by respondents in terms improvements to the documents clarity were largely centred around clarification/further information, as identified in Question 13 (see Box 23).

Box 23 – Suggestions or queries around clarity

General
"Don't forget the law/standards are often different in Scotland and I think GOsC often forgets this." *".....some clauses are unhelpful because once you attempt to formalise certain areas in what amounts to a legal framework, this always leads to the need for more and more and more clarification and when you have general/simple guidance "in principle" to avoid reams of detail you are then left areas which are open to subjective interpretation which is unfair……."* *"The language that is being used in the whole of the document is not clear and I believe should be written in plain English. It's far too bureaucratic……"* **"** *"Must/should appear muddled – must = standard, should = guidance."*
Communication and patient partnership
A2 – *replace 'understand their condition' with 'understand their presenting symptoms'.* *"A3. Objection to the use of the phrase that one 'must' ENSURE patient understanding. It is not possible to ensure that someone has understood something - change phrase to 'use best endeavours to ensure' or 'try your best'. Placing a requirement on ensuring is unrealistic and unreasonable."* *[A3] "Regarding requirement to explain 'potential risks associated with no treatment' - this is not a reasonable requirement, it should be removed……" [A3.3]*'If you are unable to communicate sufficiently with the patient, you should not treat them' - what about babies etc? Should this be reworded?" *"Repetition: A.7.1 and D.6.2. This diversity guidance makes more sense under D.6.2. A.7.1 should be removed, and the standard A.7 should refer to patient/practitioner incompatibility."* *"Is A7 aligned with D6 2? The former mentioned civil partnership the latter does not."* *"Confusion over chaperone. A.6.5 specifies which patients should be offered a chaperone; A.3.1.1 could mean all patients should be offered a chaperone. A.6.5 makes more sense."*

Safety and quality in practice
"The document places no emphasis on evidence-based practice. Surely this is an essential aim for anything that describes itself as a "profession". I appreciate, of course, that evidence is very often missing (just as it is in physiotherapy) but surely you should emphasise more the necessity to understand evidence and to act on it when it exists. Para C1.1.4 is the only mention of this. *The one thing, above all, that prevents osteopathy being regarded as a legitimate profession is the fact that some (very far from all) of its practitioners sell "craniosacral therapy". Since there is good evidence that this doesn't work, it is regarded as part of alternative medicine (ie quackery)……..″*
Professionalism
[D1] "Need to clarify what is meant by honesty and integrity″ *[D1.2] "Allowing misleading advertising – needs re-wording -Allowing misleading advertising and information about you and your practice.″* *"As D1. 2.1 stands then we are beholden to ASA limits on advertising 'including website content is legal decent, honest and truthful.' I find this guidance difficult as it is very specific to the ASA. If the time comes and the ASA is no longer the gate keeper of our advertising material, then the guidance will need to be altered. Why not make the guidance more general to start with and simply state that advertising must be in accordance with trading standards and CAP code.″* *[D1.2.3] "…… There is a great deal of difference between a medical degree that is eligible for registration with GMC, (with the World Directory of Medical Degrees being one of the tools that the GMC uses to assess this) and registered with the GMC which in actual fact does not entitle drs to practice medicine in the UK or do any clinical work. One can only practice clinical medicine in the UK if one has a licence which requires a significantly higher bar. advise therefore that a medical degree that is eligible for registration with the GMC would be acceptable phrase.″* *[D2] "….qualify what is meant by the terms personal and intimate.″* *[D2.5.6] "Re '…..<u>will</u> have involved a balance of power= 'why such a dogmatic statement?' – suggest '….<u>may</u> have involved…'.″* *[D5] "Why does the standard about how long to keep patients records say to keep patient records for "a minimum" of 8 years. Should it not be "a maximum" of 8 years?″* [D11] **"** *This refers to 'problems' with health – 'issues' would be a better word to*

use in this context, as health matters were not always 'problems'."

67. One respondent pointed out that in Communication and patient partnership, there was an inconsistency with some standards starting with 'You must', and some not. It was suggested that 'You must' be deleted so that the standards were consistent.

68. One respondent raised an issue regarding C1, and the requirement to be able to conduct an 'osteopathic patient evaluation'. This is in the context of working in the NHS, and with the example of examining someone suffering from spinal pain and sciatica (see Box 24).

Box 24 – 'osteopathic' evaluation in an NHS context

"My consultation and examination is entirely appropriate for the role (I take a case history, I ask for consent to examine the patient, I perform a standard neurological/orthopaedic examination and then agree with the patient that they need an MRI scan to establish the cause of their treatment). However, the patient has seen an osteopath previously and they assume, incorrectly, that they will receive an 'osteopathic patient evaluation' (rather than a patient evaluation by an advance osteopathic practitioner) and feed this back to their private osteopath whom encourages the patient to complain to the GOsC as I have not performed an 'osteopathic patient evaluation' as per standard C1."

69. The iO suggest some further revision of standard B2 (You must recognise and work within the limits of your training and competence) (see Box 25).

"Competence is a complex issue. It is rarely, if ever, a simple question of whether or not to treat the patient. Just as there is always some form of osteopathic treatment that can safely be delivered to any patient, there is almost certainly some form of osteopathic care that a given osteopath is competent to deliver to every patient they encounter. We therefore suggest that point 1 and 2 of the guidance are amended to:

1. *You should use your professional judgement to assess what forms of osteopathic care you have sufficient knowledge, skills and abilities to safely and competently deliver to your patients*
2. *If a patient may benefit from a form of care that is beyond your personal limits of competence, you should consider…*

It may also be helpful to give some additional guidance under point 1 to help osteopaths to frame their thinking about this. For example, this might include a

description of some of the factors they might consider when evaluating the roles they are competent to take in the patient's care and the methods or interventions they are competent to employ…"

70. The Osteopathic Sports Care Association raised some issues specific to their context in relation to the implementation of standards (see Box 26):

Box 26 – points raised by Osteopathic Sports Care Association

Communication and patient partnership
A6.2.2 – This refers to allowing a patient to get dressed/undressed without being observed. In a sports context, patients are often assessed and treated in semi private places (such as a changing room), or even in full view of others in some cases.
Safety and quality in practice
C2 – Case notes tend to be briefer in pitch-side interventions than they would be in usual practice. *C5 – ensuring practice premises are clean and hygienic. In a sports context, this is difficult. They may be stuck in an average changing room or small room somewhere.*
Professionalism
D1.1.3 – This relates to withholding treatment. They outlined a case where a marathon runner wasn't offered an MRI as they didn't want to find a problem that may have stopped him competing in one final race, although this case was a team decision made in full discussion with the athlete. *D5.7-9 Relates to disclosure of confidential information. There are cases such as suspecting a young player has suffered a concussion where they will tell everyone – parents, coach, school etc. Coaches will want to know whether a player is fit to play, or when this might be the case. It's also difficult to maintain confidentiality when assessing someone in front of a live, or even televised audience.*

71. In relation to D1.2.3, one respondent suggested making provision for where osteopaths have a dual qualification, that they should be required to explain to patients what treatment they propose which might not be deemed osteopathic practice.

Question 15: Are there any other comments regarding this document that you would like to make?

72. This is a broad question which drew some diverse comments.

15. Are there any other comments regarding this document that you would like to make?	Yes	No	Neither Yes/No
Response rate	**24**	**71**	**6**

73. A number of positive and supportive comments regarding the updated standards were made in this section, largely echoing what was addressed in Questions 1 and 2 (see Box 27).

Box 27 – any other comments

"This is an excellent piece of work and brings both clarity and simplification to the profession. Well done."

"I like the layout of document. Easy to find bits you want to find."

"Actually, I am glad I took the time to review this questionnaire. There does seem to be a lot of common sense in it and it has made me more respectful of what the GOsC gets up to…"

"Big improvement on the old standards. Much easier to consult."

"I really like the use of terminology and the fact that the standards, as a whole, appear more agile and appropriate."

"Production of a 'Standards' document is an ongoing task but the new OPS seems to have moved well with changes in social habits and expectations and has become much more of a plain English publication."

"I think the new practice standards are a definite improvement as they offer useful guidance for both practitioner & patient without coming across as rigid rules."

74. Some responses to this question touched on the issue of osteopathic identity, reinforcing comments made earlier in Questions 4 and 8 (see Box 28).

Box 28 – Osteopathic identity

"Osteopathic principles and philosophy must be at the core of what we do as a profession and at the core of our standards. They are the keystones that binds the profession and gives it purpose and direction."

"Having attended to London Meeting last night I think there were two other issues raised but probably should not be part of the standards.

1. What is osteopathy?

2. What is an advanced osteopathic practitioner?

Good questions but the Standards is probably not the place to answer them."

"B1 1.9 - In recent years research has shown that it is not possible to accurately determine clinical changes by observation, palpation and motion evaluation. Gary Fryer has written in detail about this in his two articles in two recent editions of IJOM. There is a push towards a more process based diagnosis, moving away from the biomedical approach to diagnosis…. Is it appropriate therefore to include this guidance? I believe there needs to be flexibility within the guidance and standard to allow osteopaths to adapt their practice to these new proposed diagnostic models which are not necessarily tissue based."

75. The point made above regarding the reliability of palpation was also made in one of the face to face meetings, where it was pointed out that The evidence for 'well developed palpatory skills' in B1.1.7 was weak, and that in B1.1.9, it maybe better to include reference to patients' subjective reports, or 'patients' experience'?

76. One respondent raised an issue regarding the burden of recording detailed information (see Box 29).

Box 29 – recording of information

"While I support the aims of the GOsC in principle to regulate the profession and ensure high standards with regard to patient care I feel that the heavy emphasis on written recording of every detail of risk advisement, patient queries, presence of chaperones, specific consent, advice given, etc is probably unrealistic … My main fear is that, presented with such an onerous and exhaustive list of administrative duties at every consultation Osteopaths will not even attempt to comply with them. ….. I fear the unintended consequences of this increased regulation are that many more complaints to GOsC will be referred for further investigation as the threshold for consent is now set so high."

77. Two respondents submitted proof read copies of the entire document, annotated with comments and suggestions, which were largely editorial in nature.

Question 16: Equality impact

78. This was a general question to see if the updated standards might adversely affect osteopaths or the public in relation to Equality Act protected characteristics.

16 Are there any aspects of the proposed updated Osteopathic Practice Standards 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 aspects of equality?	**Yes**	**No**
Response rate	**8**	**101**

79. Among those who thought there were aspects of the proposed updated *Osteopathic Practice Standards* that potentially could adversely affect either osteopaths or members of the public in relation to equality criteria, some of these related to issues that are not protected characteristics in terms of equality (see Box 31).

Box 31 – Comments regarding non-protected characteristics

"those in part-time practice or located remotely will struggle with the standards that infer that relationships with others is pivotal to their professional life."

"It fails to take into account different personality types who will have strengths and weaknesses in different areas. No-one is so rounded as to be good at everything & it is a fallacy to think that would be possible."

"The responsibility aspect might make you more wary to have an extended practice - ie multidisciplinary. Obviously reception staff different."

80. Some related more to the need for additional resources or to undergraduate education in this area (see Box 32).

Box 32 – Additional resources or guidance needed

"Understanding Ethnic diversity. We can be aware but it is very difficult to know the ins and outs of different cultures/expectations, etc. Some further addressing of this type of thing should be made part of the Colleges curriculum"

"Anything that is written has the potential to adversely effect those osteopaths or patients who have difficult with reading eg dyslexia (disability), or for whom English is not their first language (race). Suggest strong editing to keep to simple words where possible."

"I think there would be an impact on people who are not able to give consent as they do not have capacity. The standards do not refer me to further guidance for this patient group……. Guidance should also be given for osteopaths to evaluate if a person has capacity for giving consent. Maybe for the guidance supporting the standards there should be explicit instructions for dealing with some of the most vulnerable parts of the community. ie Trans, Learning Disabled etc."