General Osteopathic Council

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Policy Advisory Committee
13 October 2016
Research into boundaries

Classification	Public
Purpose	For decision
Issue	The collaborative development of research into boundaries.
Recommendations	1. To consider the research objectives. 2. To agree to discuss research into boundaries with other regulators and interested parties to explore opportunities for collaboration.
Financial and resourcing implications	We estimate that a budget of £30,000 should be allowed for this research which should allow for a mixture of qualitative and quantitative methods should it be commissioned.
Equality and diversity implications	Equality and diversity issues should form a part of the brief for any research in this area. The research ideas set out in this paper recognise that differing backgrounds and culture are crucial to the context within which touch is interpreted and hence, the research objectives should specifically incorporate these matters.
Communications implications	None from this paper.
Annex	None
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Background

1. The GOsC Corporate Plan 2016 to 2019 states that our aim as a regulator is: 'To fulfil our statutory duty to protect public and patient safety through targeted and effective regulation, working actively and in partnership with others to ensure a high quality of patient experience and of osteopathic practice.'

2. The Corporate Plan also describes high-level strategic objectives, including 'To promote public and patient safety through patient-centred, proportionate, targeted and effective regulatory activity.'

3. In December 2012, the General Osteopathic Council agreed an approach to commissioning research. The first limb of the approach was to 'Commission and/or conduct research that supports and informs policy development and decision making relating to osteopathic regulation (including testing the efficiency and cost-effectiveness of GOsC processes and services) to ensure that we conduct our activities to maintain and enhance patient safety and quality in a proportionate and effective way.'

4. This paper outlines potential research that would fall into a future Business Plan period in a key area related to patient safety and osteopathic regulation namely communication in the context of touch.

5. The purpose of bringing the paper to the Committee at this stage is to seek feedback about the proposal for research outlined with particular reference to our hypothesis, the gaps that we identify and the research objectives outlined.

Discussion

6. Manual therapy involves touch between a patient and a practitioner. Touch is a powerful form of communication and is often used in an intimate context between human beings. To an extent, when considered in this context, one might hypothesise that therapeutic relationships where touch is involved may give rise to greater misunderstandings in the area of communication. The way in which communications are intended, coded, transmitted to the other party, decoded and interpreted is using a lens which many of us may often use in a more intimate context. The lens with which we collectively interpret touch may be hypothesised to be greatly sensitised. The evidence that we have about patient reported concerns potentially supports this hypothesis.

7. Since 2013, the General Osteopathic Council has, in conjunction with the major professional indemnity insurers been collecting information about first point of contact concerns and complaints and using a common system to classify them to get a picture about where initial patient concerns are arising. The aim of this report is to describe the concerns relating to osteopaths and the services they provide, with a view to informing osteopathic practice, education and training, to enhance patient safety and care. Data has been collected in 2013, 2014 and 2015 and now the collated report shows the data from all three years.

8. These reports show that:

   'If we set aside the advertising complaint data: in 2015 there were 213 other concerns recorded, which is fewer than in 2014 (248), and slightly more than in 2013 (200) (Table 1).

   'With a few exceptions, the distribution of non-advertising types of concerns and complaints remains similar over the three years. Concerns raised in 2015 about osteopaths' conduct still centre on communication:
   - 'Failure to communicate effectively': 17 (17%) and
   - 'Communicating inappropriately': 12 (12%) (Table 2).
   - 'Failure to obtain valid consent – no shared decision-making with the patient' has decreased over the three years from 20 (18%) in 2013, to 14 (14%) in 2014, to 8 (8%) in 2015 (Table 2).
   - The number of complaints made about 'sexual impropriety' has increased slightly: 2013 – 12 (11%); 2014 – 13 (13%); 2015 – 14 (14%) complaints (Table 2) and
   - concerns about 'Failure to protect the patient's dignity/modesty' have risen from 6 (6%) in 2014 to 11 (11%) in 2015. Failure to protect the patient's dignity/modesty' has risen from 6% in 2014 to 11% in 2015. There is evidence also of a rising number of complaints of 'sexual impropriety' (11% in 2013 to 14% in 2015). [1]'

9. A considerable proportion of concerns relating to patient modesty and dignity and/or transgressing sexual boundaries; also feature in our fitness to practise proceedings setting aside clinical and advertising complaints.[2]

10. Because of our hypothesis and the data outlined above, we are currently undertaking a range of 'upstream' activities to support greater awareness of the particular challenges of communication in the context of touch. For example:

    - CPD in communication and consent forms a mandatory part of our new CPD scheme.
    - CPD 'programmes' (comprising 3 or 4 'bite-size' sessions across a period of a few months) in the area of communication and consent will be delivered to early adopters as part of our drive to support them to undertake the new features of the CPD scheme.
    - Undergraduate sessions facilitated for students and for faculty, support peer learning, in the area of professionalism with a particular focus on boundaries.
    - Fitness to practise e-bulletins with learning points in the areas of consent and communication and boundaries.
    - Case studies and resources in the area of consent and communication and boundaries.

[1] See National Council for Osteopathic Research, 2016, available at http://www.osteopathy.org.uk/news-and-resources/document-library/research-and-surveys/types-of-concerns-raised-about-osteopaths-and-services/ and accessed on 1 August 2016.

[2] See GOsC Council Paper, 2015, Fitness to Practise Report available at: http://www.osteopathy.org.uk/news-and-resources/document-library/about-the-gosc/council-november-2015-item-6-fitness-to-practise-report/?preview=true and accessed on 1 August 2016.

11. The General Chiropractic Council told us that they commissioned an independent review of their fitness to practise cases between 2010 and 2013, with the objective of understanding the themes arising from allegations made about chiropractors. Findings included that almost 50% of the allegations involved during this time period involved 'relationships with patients, including issues around communication and obtaining consent, maintaining professional boundaries, and privacy and dignity.'[3]

12. The report recommended that the GCC publish specific guidance about Maintaining Sexual Boundaries and this was published in 2016[4]. Implementation mechanisms are ongoing. It is of note, that our own *Osteopathic Practice Standards* review also shows that specific guidance in this area would be helpful for osteopaths. We will take this forward as part of the review.

13. But knowing whether our 'upstream' measures are the right ones to reduce the numbers of instances where a miscommunication arises and whether they are effective is difficult to measure.

What are professional boundaries?

14. Features of a professional healthcare relationship can begin to demarcate boundaries. For example:

    - Patient vulnerability
    - Trust
    - Putting the patient first
    - Ethics
    - Integrity.

15. Behaviour which begins to compromise any of these areas can be a breach of professional boundaries. Further detail about this is provided in the CHRE reports.

What is the impact of breaches of boundaries for patients?

16. The impact of breaches of boundaries on patients can be significant. One might also hypothesise that the impact for practitioners of a miscommunication may be significant too. The Council for Healthcare Regulatory Excellence (CHRE and now the Professional Standards Authority) published a series of research-informed papers about boundaries transgressions and much of the content in this paper is based on that research. The suite of papers is available at: http://www.professionalstandards.org.uk/publications/detail/clear-sexual-boundaries /

[3] See General Chiropractic Council, 2014, Independent Review of General Chiropractic Council Fitness to Practise Cases 2010 – 2013, available at http://www.gcc-uk.org/UserFiles/Docs/Thematic%20review%20of%20ftp%20cases%202010-2013%20PUBLIC%20FINAL.pdf and accessed on 1 September 2016.

[4] See General Chiropractic Council, Guidance on Maintaining Sexual Boundaries, 2016, available at: http://www.gcc-uk.org/UserFiles/Docs/Guidance/Guidance%20on%20maintaining%20Sexual%20Boundaries-final.pdf and accessed on 1 September 2016.

17. The CHRE report *Learning about sexual boundaries between healthcare professionals and patients: a report on education and training*, 2008 explains that the literature review showed that patients can suffer 'significant and enduring harm' as a result of sexualised behaviour being displayed towards them. These harms can include:

    - 'post traumatic stress disorder and distress
    - major depressive disorder
    - suicidal tendencies and emotional distrust
    - high levels of dependency on the offending
    - professional, confusion and dissociation
    - failure to access health services when needed
    - relationship problems
    - disruption to employment and earnings
    - use and misuse of drugs and alcohol'
    - Breaches will often affect the professional's judgement thus impacting on patient care.'

18. Thus, having the right guidance in place, and identifying appropriate education and training and support and ensuring that these are effective are vital for patient safety.

19. The McGivern report[5] shows us that relational regulation is a key component of compliance with standards. When osteopaths understand the 'why' not just the 'what' they are more likely to comply. We need to explore further whether we are doing the right type of 'upstream activities' to support osteopaths and patients in this difficult area, whether what we are doing is effective, and what else we could be doing to be more effective in this area. We currently do not have data on this.

20. However, it is not just about what we do as a regulator; relationships with our stakeholders in this area are also important. Appropriate organisations both within the osteopathic environment and in the healthcare environment more broadly may also have a role to play to support patient safety.

Commissioning research and policy recommendations

21. As this is such an important area for patient safety and well-being, we would like to explore the possibility of commissioning research to help us to understand the issues more clearly and to help us to form policy recommendations to better support patient safety, well being and the quality of care.

22. We suggest that the objectives of the research may include the following:

    - To get a better understanding of the current context, cultural environment, societal views, professional views and public views about communication,

[5] See McGivern G et al, Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice, 2015 available at: http://www.osteopathy.org.uk/news-and-resources/research-surveys/gosc-research/research-to-promote-effective-regulation/ and accessed on 5 October 2016.

touch and boundaries to help us to determine what more regulators and other stakeholders could be doing in this area to protect patients (as touch is so culturally and context specific, we think that a more in depth exploration in this area is important to help us to understand more clearly the lenses through which touch is construed).

- To demonstrate what activities are effective in supporting communication between individual patient and particular clinician?
- To advise on what further actions might be taken – either ourselves as a regulator – or in partnership with others to protect patients? (For example, actions may include the production of guidance or revision of existing guidance, but also need to focus particularly on effective mechanisms for implementation both for practitioners and patients. In this context, consideration should be given to the findings of the McGivern report.)
- To advise on mechanisms for helping us to understand how will we know whether any action that we take has been effective in achieving our goal? (For example, is a decrease in fitness to practise cases reported a success or a failure in this area?)

23. It is expected that the researchers would propose precise research questions to deliver the objectives of our research using an appropriate theoretical framework and proposing proper methodologies to ensure academic independence and integrity in the work. (For example, we would expect a mixture including a literature review, and qualitative and quantitative methodologies to explore the research questions appropriately.)

24. It will be important that the research is academically robust but also that it translates into practical advice and recommendations to regulators and others about how to achieve our objectives along with advice about how we might measure the success of achieving our objectives.

The Policy Advisory Committee is asked to consider the proposal for research outlined above with particular reference to our hypothesis, the gaps that we identify and the research objectives outlined above and to provide feedback.

Next steps

25. As this is such a broad area which may be of interest to other professions, for example, chiropractors, physiotherapists, general practitioners, obstetricians and gynaecologists, we would like to explore our proposals for research with other regulators and other interested parties to develop a collaborative commission.

26. We would plan to open discussions with other regulators and other interested parties over the course of the next few months with the aim of developing a collaborative research proposal of interest to all.

27. We will report back progress to the Policy Advisory Committee in spring 2017.

Recommendations:

1. To consider the research objectives.

2. To agree to discuss research into boundaries with other regulators and interested parties to explore opportunities for collaboration.