General Osteopathic Council

# *Osteopathic Practice Standards*
# Consultation analysis and report

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## Introduction

1. This document should be read in conjunction with the report on the consultation outcomes in relation to updated *Osteopathic Practice Standards* (OPS). This report considers the consultation responses, which have been grouped under the following headings:

    - General
        - Structure
        - Clarity and accessibility
    - Communication and patient partnership
    - Knowledge, skills and performance
    - Safety and quality in practice
    - Professionalism

    Analysis on the consultation responses is offered, along with proposed approaches in relation to issues raised.

2. Some amendments have been made to the consultation draft of the *Osteopathic Practice Standards.* These reflect the proposed approaches set out within this report, as discussed with the Stakeholder Reference Group[1]. The updates are summarised in the appendix to this document.

3. As is reported in the report on consultation outcomes, the total number of responses via the consultation website was 227, with an additional 91 emails making a total of 318 responses. This is a relatively high response rate when compared to similar consultations.

4. In addition, a range of engagement events and activities were undertaken, including:

    - 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 (BCOM, 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.

[1] The Stakeholder Reference Group was established to provide stakeholder advice and input to the review process. It has representatives from the Institute of Osteopathy, The Council of Osteopathic Educational Institutions, The National Council for Osteopathic Research, The Osteopathic Alliance and patients.

5. These increased the reach of the consultation and generated feedback in addition to that received via the website or by email. Overall, in addition to the online consultation, more than 200 people were directly engaged with in meetings and presentations about the updated standards.

6. For comparison, when the current *Osteopathic Practice Standards* were consulted on in 2010, there were 160 responses to the electronic questionnaire, plus 89 telephone interviews and 13 focus group meetings.

7. The Institute of Osteopathy (iO) provided an official response to the consultation. The iO are the professional body, representing 3,864 members, which is some 70% of osteopaths in the UK.

**Analysis – General**

*Structure*

8. Question 1 of the consultation related to the overall structure of the updated OPS, in particular:

    a. The combining of the Standard of Proficiency and the Code of Practice
    b. The retention of the current four themes of the OPS:
        - Communication and patient partnership
        - Knowledge, skills and performance
        - Safety and quality in practice
        - Professionalism

9. Of the 132 responses received to this question, 92.5% supported the proposed structure, with some positive comments made as to the document's clarity and navigability.

10. Some respondents who did not support the updated structure commented that it was too complicated or jargonistic, or that there was no evidence as to the impact of the standards on osteopathy today.

11. No one challenged the feasibility or usefulness of combining the Standard of Proficiency and Code of Practice into one overarching set of standards which simultaneously became both Standard and Code.

*Discussion*

12. In relation to the point made that there is no evidence of the impact of standards on 'osteopathy today', it is suggested that this would depend upon the criteria by which this is measured. The standards relate to the breadth of osteopathic care of patients, and patients' experience of this – rather than being focussed just on the technical aspects of 'doing osteopathy'.

**Proposed approach**

Maintain the proposed structure of the updated standards with combined Standard of Proficiency and Code of Practice, and the four existing themes of the OPS.

*Clarity and accessibility*

13. Question 2 asked whether the updated OPS document was clear and accessible. Of the 126 respondents to this question, 82% indicated that this was the case, with some commenting that the document is clear and much easier to understand than the current version.

14. Question 15 asked whether respondents had any other comments to make regarding the OPS. These included a number of positive comments which echoed some of those made in response to questions 1 and 2. Again, comments were made that the updated OPS were '*a big improvement*', '*more agile and appropriate*' and bring '*clarity and simplification*'.

15. Some respondents who did not feel that the updated OPS were clear and accessible indicated that there were still areas of repetition, ambiguity or conflicting wording, though did not indicate where this occurred. In contrast to those who felt the document was clear and easy to read, some felt that this was not the case and needed to be rewritten in plain English.

16. Question 14 asked whether respondents had any suggestions to enhance the clarity of the document. Of the 111 responses, 75% had no further suggestions to make. Of those who did have further suggestions, some related to general issues, such as the need to review the use of 'must' and 'should' within the guidance. One pointed out that the laws in Scotland are often different to the rest of the UK, and that '*the GOsC often forgets this',* though it was not then indicated where this had occurred in the document.

17. One respondent pointed out an inconsistency with the standards in the 'Communication and patient partnership' theme, where some start with 'You must' and some do not.

*Discussion*

18. In the current *Osteopathic Practice Standards* the Standards of Proficiency tend to commence with 'You must', whereas the Code of Practice does not. The fact that these have now been combined into one set of standards means that this variation in wording is reflected in some standards as a legacy of the current wording.

19. The rationale for including 'must' and/or 'should' within standards and guidance was agreed during the drafting process. This was as follows:

- If 'you must' is included within the standard, it's not always essential in the guidance.
- If there is a legal requirement, then 'you must' is required.
- If 'you must' is not included within the standard, then consider its inclusion within the guidance to that particular standard.

20. In the consultation draft of the *Osteopathic Practice Standards*, 22 of the 29 standards commence with 'you must'. On reflection, to ensure consistency through the document, it is proposed to add 'you must' to the seven standards where this is not the case. These are highlighted in the changes in the appendix to this document.

21. With regard to the comment around laws in Scotland being different, the document has been reviewed once again to ensure that there is no mention of anything which does not relate to all four countries of the UK.

**Proposed approach**

For consistency, commence all standards with 'you must'.

## A. Communication and patient partnership

22. In updated standard A4 of the OPS*,* 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. Question 3 asked whether the updated guidance is sufficient to support the implementation of the standard.

23. There were 114 responses to this question with 83% indicating that the guidance is sufficient to support implementation of the standard.

24. Some respondents felt that the guidance was sufficient, but suggested further enhancements to the guidance some areas. Some felt it was not sufficient, and commented on a number of issues or specific paragraphs. These are set out in the report on consultation outcomes, and are summarised below, together with discussion in each case:

*Process of gaining consent*

25. This centred around the perception that 'every manoeuvre, touch, expression needs to be consented for' and that this is overly onerous, particularly with regard to A4.2.

26. A4.2 states '*The gaining of consent is an ongoing process. You must ensure that patients are able to make decisions at all stages of their treatment and care, and continue to give consent'*. This is consistent with the law, and in line with guidance given to other healthcare professionals, and would not be modified

within the OPS. The point does indicate, however, that there is not always a consistent understanding of what 'ongoing consent' means, and how this can be effectively achieved.

27. There is only so much guidance that can reasonably be included within a standards document, but other resources are, and may be, produced to support the effective implementation of standards. The GOsC already publishes consent guidance for England and Wales, Scotland and Northern Ireland, together with scenarios which outline capacity issues, on our website. There are also resources around the communication of risk, '*what is valid consent'*, and '*putting patients at ease'*. The research commissioned by the GOsC in adverse events in osteopathy and patient expectations of osteopathic care, are also presented on our website.

*Paediatric treatment*

28. One respondent referenced A4.15 to allude to a scenario where there may be a conflict between a parent's wishes and those of a child who is capable of giving informed consent.

29. A4.15 states: '*A child may have the capacity to consent, depending on their maturity and ability to understand what is involved. You will need to apply the law, and use your professional judgement in assessing the capacity of each patient under 16 years. You are strongly advised to involve a person with parental responsibility for the child when seeking consent*.'

30. The GOsC's guidance document '*Obtaining Consent'* is already referenced as a source of further information in A4.14, and A4.17 further references capacity of 'young persons':

    *'A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing for them because, as with adults, consent must be valid.'*

31. The guidance within the standards document is intended to provide a framework to support the implementation of the standards in practice, rather than detailed advice to cover every scenario. Osteopaths are expected to use their professional judgement to reflect on clinical situations and consider how the standards are best implemented in any given circumstance.

*Montgomery judgment*

32. One respondent suggested specifically referring to the Montgomery judgment[2] in relation to the explanation of risks.

[2] https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf

33. This might relate to A3.2 (*inform your patients of any material or significant risks associated with the treatment you are proposing*…..', as well as A4.6 (*the patient needs to understand the nature, purpose, benefits and risks of the examination and treatment proposed*). It is felt as long as the wording is consistent with the judgement, then it does not necessarily need to be specifically referenced. This would avoid the guidance becoming out of date if a further judgement superseded Montgomery, for example. Again, guidance around Montgomery is published separately on our website for osteopaths.

*Recording consent*

34. Some respondents requested more guidance as to how consent should be recorded.

35. A4.18 states: *'You must record key elements of your discussion with the patient. This should include information discussed, any particular concerns, expectations or requests for information raised by the patient, how you addressed these, and any decisions made. It is important that such issues are evidenced in the patient records.'*

36. Within a standards document, it is not thought that it would be feasible to provide more detailed guidance as to how consent should be recorded, though the consultation process has highlighted that some osteopaths are unsure about this. Again, this is an area around which additional resources might be developed.

*Use of language*

37. Some respondents commented in relation to:

    - consistency called for regarding use of 'must' and 'should' in A4 guidance
    - A4.6 – a suggestion to use the phrase 'material and significant risks' so as to be consistent with A3.2.
    - A4.6 – what is a suitable length of time for a patient to reflect on what has been proposed by way of treatment.
    - A4.19 Rephrase to describe or give examples of how voluntariness can be captured.

38. In relation to the use of 'must' and 'should' within the guidance, the rationale for this was set out in 13 above. In some cases, the guidance reflects a legal requirement, which is where 'must' has been used.

39. In relation to the phrase 'material and significant risks', it would, indeed, improve consistency if this was mentioned in A4.6 as well as A3.2. Further, that reference to 'benefits and risks' in A3.2 should be 'to the patient'.

40. Again, in relation to A4.6 reference is made that '*some patients may need time to reflect on what you have proposed before they consent to it*.' It is not thought appropriate to stipulate more here as to how long this might be, as it will depend on a wide range of issues.

*Other comments relating to communication and patient partnership*

41. One respondent felt that A6.2 was too prescriptive, and that A6.1 on its own would be sufficient. A6.2 gives guidance around respecting patients' dignity and modesty by providing an explanation in advance that they may be asked to undress, letting them undress and dress again unobserved (there is flexibility on this where it seems appropriate to remain in the room) and by providing a cover for areas of the patient which do not need to be exposed for examination or treatment. This is an area where some osteopaths seem unsure about what the requirements are, as was seen in the research conducted by Professor Gerry McGivern et al on the compliance with standards in practice[3]. In view of this uncertainty, it does seem appropriate to have this additional element of the guidance. The guidance is flexible, but provides an example of how the standard might be implemented.

42. Again in relation to A6.2 some respondents who work in a sports context pointed out that sports patients are often examined and or treated in semi-private places, or even in full view of others. From a standards perspective, this would be seen as a contextual issue, however. Although the standard is a requirement, how it is implemented will depend on the context in which the osteopath is working. In a sports setting, the osteopath's particular role, local policies and procedures will all have an influence.

43. One respondent raised a particular issue around A3.1.1 and A6.5 and the guidance given around chaperones. A3.1.1 states that before examining or treating a patient, the osteopath should ensure that the patient understands their rights, '*including the right to have a chaperone present*…….' A6.5 states that osteopaths must always ask a patient if they would like a chaperone when examining or treating an intimate area, treating anyone under 16 years of age, treating an adult without capacity or treating a patient in the patient's home. The point made was that the requirement to inform all patients of their right to a chaperone was not reflective of normal osteopathic practice. Further that this explicit obligation, in the respondent's experience, is not enforced. The suggestion is to conflate these guidance paragraphs and be clearer about what is required.

44. Having reviewed the language of the standards and guidance in question, it is considered that there is a difference between informing a patient of a general right to have a chaperone during treatment, and the specific need to ask a

[3] http://www.osteopathy.org.uk/news-and-resources/research-surveys/gosc-research/research-to-promote-effective-regulation/

patient if they would like a chaperone in the circumstances outlined in A6.5 and thus no change is proposed here.

**Proposed approach**

Amend the first sentence of A.6 to *'The patient needs to understand the nature, purpose, benefits and material or significant risks to them of the examination or treatment proposed.'*

Add 'You must' to A1, A3, A5 and A6.

See the appendix to this document for other editorial suggestions.

## B. Knowledge, Skills and Performance

*Standard B1: Philosophy and Principles*

45. Question 4 related to how osteopathic philosophy and principles should be referenced within the standards. Three options were given for respondents to consider:

    - 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

46. The GOsC suggested version in the consultation draft is in line with option 2. Updated standard B1 says; '*You must have sufficient and appropriate knowledge and skills to support your work as an osteopath.'* The guidance to this standard then provides a detailed outline of what these skills and knowledge should comprise, including: '*an understanding of osteopathic philosophy, principles and concepts of health, illness and disease, and the ability to apply this knowledge critically, in the care of patients.'*

47. This proved a contentious issue amongst some respondents, generating a significant response. There were 296 responses overall, with 243 (82%) favouring option 1, 45 (15%) favouring option 2, and 8 (3%) favouring option 3.

48. The Osteopathic Alliance lobbied their member organisations to respond in favour of option 1, suggesting a form of words which a number utilised or adapted.

*Discussion*

49. The nature of osteopathic philosophy and principles, and their application, in practice is a contentious, and potentially divisive issue. This can be seen from the nature of the comments made by respondents to this question. Many see osteopathic principles as a central element to their practice and professional identity. They regard these as the defining characteristic of osteopathy, distinguishing it from other healthcare approaches. Others regard osteopathic principles as, at best, of historic interest, and at worst, out of date dogma which no longer stands up to academic or scientific scrutiny. Opinions on this can be polarised, as can be seen from the feedback.

50. There is also a central ground, with a number of respondents favouring option 2 as representing a flexible approach to this issue, acknowledging that a critical understanding of osteopathic philosophy and principles is necessary to support work as an osteopath, but not cementing this within a standard. Some pointed out that it would be difficult to enforce a standard when the concepts under discussion were not universally agreed or applied in practice.

51. These differing views are well established within the profession. An edition of the International Journal of Osteopathic Medicine in 2013 focussed on this particular subject, with papers upholding the principles as definitive of osteopathy(Paulus[4]); suggesting that they were no longer particularly unique (Tyreman[5]) or were largely out of date and in need of review (Evans[6]).

52. This was evident, also, within the 2016 call for evidence in which views were sought from the profession on the application of the current standards. For example:

    *[In relation to current B1* – 'You must understand osteopathic concepts and principles and apply them critically to patient care'*]*

    *"Should there be mention here of an understanding of osteopathic PHILOSOPHY? As osteopathic principles are derived from osteopathic philosophy understanding of the latter is more important."*

    *"seems unnecessary as it is fundamental to becoming an osteopath. What is meant by critically in this standard? Should clinical decision-making also be informed by evidence (not necessarily osteopathic)and arguably values too. Much of clinical work is not simply informed by osteopathic principals and concepts, practitioners will be drawing expertise from many sources -*

[4] Paulus, S; '*The core principles of osteopathic philosophy* ', International Journal of Osteopathic Medicine (2013) 16, 11-16
[5] Tyreman, S; '*Re-evaluating 'osteopathic principles'* , International Journal of Osteopathic Medicine (2013) 16, 38-45
[6] Evans, D, '*Osteopathic principles: More harm than good*?', International Journal of Osteopathic Medicine (2013) 16, 46-53

*physiotherapy, pain science, general medicine, psychotherapy, physical therapy etc. etc"*

*"I feel it's important to have an awareness of where osteopathy has come from, but furthermore, where we are now, in terms of what research suggests, even if it doesn't support earlier claims of the principles. The 'Applying them critically' part must be emphasised. I think 1.1 'using (principles) to INFORM clinical decision making' allows for too much emphasis on interpretation of subjective findings such as palpation."*

*"How can one know if an osteopath understood and followed the principles and concepts of osteopaths when the principles and concepts are not clearly defined?"*

*"B1 (1.1) refers to the principles and concepts of Osteopathy. What are these? What is their precise relationship to the Standards? Do they supervene over the Standards? If so, how, and when?"*

53. It was this apparent lack of consistency and agreement around what osteopathic principles and philosophy are, and how these should be applied in practice, that prompted the suggestion that current standard B1 (*You must understand osteopathic concepts and principles, and apply them critically to patient care*) be removed in the updated standards, and instead featured within the list of knowledge and skills required to support work as an osteopath in the updated B1.

54. It was highlighted within the consultation document, and is worth considering again here that that, since the current standards were implemented in 2012, the GOsC has published *Guidance for Osteopathic Pre-registration Education*[7] which sets out the outcomes students are expected to meet in order to graduate with a Recognised Qualification (enabling them to apply for registration with the GOsC). The Quality Assurance Agency *Subject Benchmark Statement for Osteopathy*[8] also sets out requirements in relation to osteopathic education. Both of these documents refer to the osteopathic principles and philosophy. For example, the *Guidance for Osteopathic Pre-Registration Education* requires that graduates have a range of knowledge and skills, which include an ability to:

*"Know how osteopathic philosophy and principles are expressed and translated into action through a number of different approaches to practice."*

55. The *Subject Benchmark Statement for Oste*opathy (2015) sets out clear expectations regarding students' developing understanding of osteopathic concepts and principles, and translating these into treatment and management approaches to meet the needs of patients, and states:

[7] www.osteopathy.org.uk/training-and-registration/becoming-an-osteopath/guidance-osteopathic-pre-registration-education/
[8] www.qaa.ac.uk/en/Publications/Documents/SBS-Osteopathy-15.pdf

*"Osteopathic practice seeks to blend a philosophical approach with intellectual and practical skills to guide the use of therapeutic intervention to help the patient by using an individual 'package of care' most suited to their needs."*

56. There is, arguably, therefore, less need to be so explicit within the standards as to the nature of knowledge and skills required of registrants, so long as this is sufficient and appropriate to support their work. Those undertaking 'Recognised Qualifications' will have achieved the required outcomes and have the knowledge and skills set out in the guidance to B1.

57. Some osteopaths apply to join the register not having undertaken a recognised qualification, for example, those who trained in the EU or Switzerland[9], or in other countries[10]. During the consultation, a query was raised in this context around such applicants; how, if there is no reference to the principles and/or philosophy of osteopathy within a standard, would they be assessed as having the necessary knowledge in this regard to inform their work as an osteopath. The concern was that if the distinctive aspects of osteopathy were lost from the standards, those from other similar professions might be able to demonstrate sufficient compliance to the *Osteopathic Practice Standards* to join the register.

58. In the case of updated B1, the knowledge and skills required to support work as an osteopath are clearly set out within the guidance, including, now, reference to '*osteopathic philosophy, principles and concepts of health, illness and disease*'. and would inform the assessment of any such applications. Applicants are required to submit a range of material, including:

    - proof of qualification
    - if no qualification held, evidence that they have practised as an osteopath for at least one of the last 10 years
    - a certified copy of their academic transcript, which outlines the results achieved for each module studied
    - a course guideline/handbook which outlines the modules studied, specific to osteopathy

59. The documents in support of the application are sent to two trained registration assessors who will decide whether there is, or is not, a substantial difference between the applicant's training, work experience and professional development and the UK standards. These standards will include the updated B1, which requires that osteopaths have sufficient and appropriate knowledge to support their work as an osteopath. The guidance to this standard clearly sets out what this should include, and will be used as a reference to underpin the assessment process. It is therefore felt that the moving of reference to osteopathic principles from a standard to guidance, does not create a risk in terms of applications from internationally qualified applicants.

[9] http://www.osteopathy.org.uk/training-and-registration/how-to-register-with-the-gosc/i-trained-in-the-eueea-or-switzerland/

[10] http://www.osteopathy.org.uk/training-and-registration/how-to-register-with-the-gosc/i-trained-outside-the-eueea-and-switzerland/

60. It was further pointed out in the consultation document that osteopathic philosophy and principles are owned and defined by the profession, rather than the regulator. It is not the role of the regulator to enforce a particular interpretation of osteopathic principles, when an osteopath is otherwise working in accordance with the practice standards.

61. The significance of this issue to many osteopaths is clear from the responses received. The 243 respondents in favour of option 1 (having reference to the principles within a standard) represents some 5% of the profession. The fact that the Osteopathic Alliance lobbied member organisations to campaign for this option seems to have increased the numbers. Many responded using the identical wording suggested by the Osteopathic Alliance:

    *"Osteopathic philosophy and principles should be a Standard, not downgraded to Guidance."*

62. As has been seen, however, although there is strong feeling that osteopathic identity is embedded within its philosophy and principles, this is far from universally agreed within the profession. The challenge, therefore is to acknowledge the significance of osteopathic philosophy, principles and concepts of health within the standards, but to do so in a way that is not overly prescriptive, or which prevents osteopaths interpreting and applying such concepts in a way which reflects their osteopathic approach.

63. Despite the views expressed by many in response to the consultation, it is still considered that option 2 outlined within the consultation document (referring to philosophy and principles within the guidance to new standard B1) represents the most pragmatic and flexible way of managing this issue. The Institute of Osteopathy, in their official response to the consultation also felt that option 2 represented '*a balanced approach allowing a degree of flexibility in individual belief and interpretation*'.

64. At the post-consultation Stakeholder Reference Group meeting, this question was discussed extensively, with full consideration being given to the issues outlined above. Despite some varied views within the member groups a consensus was reached that Option 2 was a pragmatic and appropriate approach to referring to osteopathic principles and philosophy, though it was suggested that the paragraph in question be moved to the top of the list of guidance and become B1.1.1. Although the contents of the guidance are not in order of priority, having the philosophy and principles reference first seemed appropriate. Further, it was pointed out in regard to B1, that the issue is not just having sufficient knowledge and skills to support work as an osteopath, but being able to apply these. The suggestion, from the group, therefore, was to amend B1 to reflect this.

**Proposed approach**

Retain the option 2 approach proposed in the consultation draft, with an understanding of osteopathic philosophy, principles and concepts of health, illness and disease referenced in the guidance to B1 as being an aspect of the knowledge and skills required to support work as an osteopath. This reference should become 1.1 within the guidance to B1.

Further, B1 should be amended to: '*You must have and be able to apply sufficient and appropriate knowledge and skills to support your work as an osteopath'*

65. A further point was made during the consultation around an aspect of the B1 guidance, featured in B1.7 (well developed palpatory skills) and B1.9 (the ability to determine clinical changes by the appropriate use of observation, palpation and motion evaluation). This centred on the lack of reliability of palpation, and the need to allow osteopaths to adopt approaches to diagnosis which reflected contemporary thinking, moving away from a purely biomedical model. This also applies to C1.6 (adapt an osteopathic technique or treatment approach in response to findings from palpatory examination).

66. The question of palpation was discussed during early Stakeholder Reference Group meetings. Although it was acknowledged that the reliability of palpation and palpatory diagnosis was sometimes poor, it was nevertheless felt to be an intrinsic aspect of osteopathic practice. Its inclusion in the form suggested was thought to be appropriate within the context of osteopathy as a therapy with a largely (though not exclusively) hands-on approach, and was balanced by the broader range of knowledge and skills set out within the guidance.

*Standard B2 – Recognising and working within limits of training and competence*

67. The Institute of Osteopathy raised a point around this standard. They state that competence is a complex issue, and that there is nearly always some form of osteopathic treatment that would be suitable for a patient, and some form of care that any given osteopath is competent to deliver. They suggest rewording the guidance to this standard as follows:

    i. *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*
    ii. *If a patient may benefit from a form of care that is beyond your personal limits of competence, you should consider…*

68. They also suggest expanding the guidance to help osteopaths frame their thinking around this – for example, the factors that that might help them consider their competence in any given situation.

*Discussion*

69. The current wording of B2 guidance states:

    *"You should use your professional judgement to assess whether you have the training, skills and competence to treat a patient.*

    *If not, you should consider…"*

70. The intent of the standard is to ensure that osteopaths recognise and work within the limits of their training and competence. The iO's suggestion potentially dilutes this by removing reference to training. Its underlying assumption also is that there will always be some form of osteopathic care that it's safe for an osteopath to deliver. Whilst this may well be the case in most instances, the current wording will achieve the same end without necessarily making this assumption.

**Proposed approach**

The proposal is to retain the B2 standard and its guidance as set out in the consultation draft.

*Standard B4 – analysing and reflecting on information to enhance patient care*

71. This standard states: '*You must be able to analyse and reflect upon information related to your practice in order to enhance patient care'*. The guidance explains how this would be implemented:

    *'To achieve this you will need to have sufficient knowledge and ability to collect and analyse evidence about your practice to support both patient care and your own professional development.'*

72. Question 5 of the consultation asked whether this and its supporting guidance were clear and easy to use. Of the 131 responses to this question, 88.5% indicated that the standard and its guidance were sufficiently clear.

73. Some of the comments from the 11.5% of respondents who did not feel the standard and its guidance were clear indicated that they were still unsure what it meant, and how it should be implemented. One was not sure what 'related to your practice' meant in this context, and one asked, 'what information is to be analysed, for what purpose, and for who?'

*Discussion*

74. This standard is a modified version on the current D3 which states 'You must be capable of retrieving, processing and analysing information as necessary'. Feedback indicated that this standard was not always well understood, and the

proposed modification was aimed at addressing this, focussing the requirement around patient care. The points made in criticism partly reflect the fact that this is flexible. It is not a requirement to audit or conduct generalised research on patient data, but those activities might demonstrate that the standard is being met. The standard is *to be capable of* analysing and reflecting upon information. Undergoing the objective activity requirement of the new CPD scheme when implemented, would be a way of achieving this, but it's about the capability rather than a prescribed activity.

**Proposed approach**

Accept the standard as proposed.

## C. Safety and quality in practice

*Standard C2 – guidance for recording patient information*

75. This standard requires that osteopaths ensure that their patient records are full, accurate, legible and completed promptly. The updated guidance is aimed at enhancing clarity around this, with an additional reference made regarding the recording of the presence of observers and patient's consent to their presence.

76. Question 6 asked whether this standard and its guidance were clear and easy to use. 133 responses were received, of which 127, (95.5%) agreed that it was.

77. One respondent asked for a definition of 'full' and 'promptly', and one suggested a re-ordering of the sequence of listed contents to reflect a patient encounter, and make specific reference to any chaperone.

*Discussion*

78. It is noted that 95.5% of respondents to this question felt the guidance was clear. The request by one respondent for further clarification around the definition of 'full' and 'promptly', although in the minority, may indicate that some are unsure exactly what is meant by this. This is another area where some additional learning resources may help to support osteopaths in implementing the standards in practice. The reference to chaperones is noted.

79. Although 95.5% of respondents felt the guidance was clear, the comments regarding clarity made by some of those who did not find it so clear were well made. The wording has been revisited and modifications suggested to improve clarity, reference chaperones, and ensure the language between the standard and guidance is consistent by use of 'comprehensive' rather than 'full'.

**Proposed approach**

Proposed modifications to C2 guidance are set out in the table in the appendix and in the updated draft *Osteopathic Practice Standards*.

Consider development of resources around recording patient information during implementation phase.

*Standard C3 – production of written material and data*

80. This standard states '*you must respond effectively to requests for the production of written material and data'*. The guidance refers to production of reports and information to support patient care and effective practice management.

81. Question 7 asked whether the updated standard was sufficiently clear and easy to use. There were 115 respondents, of which 105 (91%) indicated that it was.

82. One respondent suggested that examples of circumstances in which this might apply would be helpful, together with reference to potential confidentiality issues of producing reports concerning patients.

83. Of the 10 respondents who felt the standard was not clear, the comments indicated that the standard was not specific enough, and queried definitions of 'effective' and 'high quality'.

84. One respondent raised an issue which they felt was a recurring theme – that C3.1 suggests only that osteopaths 'be able' to produce reports, rather than actually do so. This contrasts with C3.2 which specifies that osteopaths must 'develop mechanisms….' This was described as a variability which can induce stress and lead to non-compliance.

*Discussion*

85. This standard is an updated version of the current D2, now moved to the 'Safety and quality in practice' theme. Feedback on the current standard D2 was that it was not well understood, and the modifications are aimed at increasing clarity around the intent of the standard. A high proportion of respondents felt that it is now clear and easy to use.

86. With regard to the comment requesting further clarity around definitions of 'high quality' and 'effective', again, though a minority view, it is interesting to note that some do not regard these as self-evident.

87. As to the comment that C3.1 (now modified to C3.1.1) says 'be able to produce', rather than 'produce', this is actually guidance. The standard indicates that osteopaths 'must respond effectively….', and the guidance goes on to explain that to achieve this, they will need 'to be able to produce reports and referrals ….' It could be argued that the requirement to 'do' something, rather than just 'be able to do' something, is embedded in the standard itself, though deleting 'be able to' from C3.1.1 would make for greater consistency.

**Proposed approach**

Delete 'be able to' from C3.1.1

*Standard C6 – The promotion of public health*

88. C6 states '*Be aware of your role as a healthcare provider to promote public health'*. This wording is unchanged from the current version of the standard, where it is D11. The current guidance, however, is not particularly helpful in explaining what implementation of this standard would comprise, and therefore the guidance has been updated 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.'*

89. Question 8 asked whether the updated guidance is clear, and adequately sets out the appropriate position of osteopathy in relation to public health. As seen from the report on the consultation, this issue drew a significant response. There were 295 responses overall, with 234 (79%) opposed to the wording, and 61(21%) in favour.

90. The Osteopathic Alliance lobbied its member organisations to oppose the wording of the standard, the main issue being around the use of the word 'promote' in relation to public health. Interestingly, the updated guidance was generally accepted, with the unchanged standard being the focus of comment. Some feedback indicated that 'balanced' would be preferred over 'impartial' in the guidance.

91. Many respondents used wording suggested by the Osteopathic Alliance to suggest revised wording, for example:

    '*Be aware of your role as a healthcare provider with regard to public health'*

92. Some objected to the standard altogether, arguing that osteopaths do not have a role in promoting public health. This is seen by some as the promotion of government health policies which may be at odds with an osteopathic viewpoint or values.

93. The iO, who promote their own 'supporting public health' campaign through their journal 'Osteopathy Today', also said that this standard should not '*under any circumstances be interpreted as a blanket requirement to promote public health policy'.* They suggest a revised wording based on the NMC's standards of competence for professional midwives:

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

94. Although the modified guidance seemed to generally be supported, some saw this as implying that osteopaths were being required to have an extensive knowledge of unspecified public health issues. The iO has suggested rewording the first sentence of the guidance to:

    *'You should be aware of public health issues and concerns that are relevant to your practice…..'*

95. Others felt that 'in a balanced way' was preferable to saying 'impartially within the guidance to C6.

*Discussion*

96. Despite this standard having been in force since 2012 with no issues or objections having arisen, it has clearly caused some consternation within the profession. Its intent was never to require osteopaths to give health advice which conflicted with their own values, but to have an understanding of public health issues, and be able to signpost patients to resources or other healthcare professionals to support decision making around these. The aim is to acknowledge the role that osteopaths, as regulated healthcare providers, have within the promoting health within the community.

97. The iO's Supporting public health campaign, cites, for example, the NHS One You site[11] and Active 10 campaign[12]. These deal with issues such as smoking cessation, alcohol consumption, exercise, stress management and weight loss and osteoporosis management. Osteopaths would not be expected to have an in depth understanding of every issue affecting public health, but it would seem reasonable to have an awareness of the types of concerns which commonly affect patients.

98. The iO's suggestion for alternative wording to C6 is a helpful one. With regard to the suggestion to modify the guidance to relate to public health issues and concerns that are relevant to your practice, however, it is felt that this is implicit within the suggested wording, and it would be hard to think of a public health issue which might not have an impact on osteopathic practice, regardless of the views of the osteopath around this.

99. The Professional Standards Authority (PSA) and the Royal Society for Public Health have recently published a report on a study of the role of practitioners of accredited registers (AR) in supporting the public's health. They state that '*the AR workforce is in contact with members of the public thousands of times every day, and on each occasion there is scope to pick up on possible signs of lifestyle health issues, taking steps to support their associated health needs'*. They refer to 'healthy conversations' in which an individual is encouraged to consider their lifestyle and health with a view to identifying small but important changes, and

[11] https://www.nhs.uk/oneyou#fPWijpZsEMicK0OI.97
[12] https://www.nhs.uk/oneyou/active10/home#f8SA47U7A1yyfcLK.97

conclude that practitioners on accredited registers make a large contribution to promoting the public's health.

100. If the role of accredited professions in the promotion of public health issues is being acknowledged and developed, then it could be argued that there is a demonstrable need to make reference to this within the standards of a regulated healthcare profession such as osteopathy.

101. It is worth considering that, to an extent, part of the intention of C6 is already encapsulated in Standard A5, which states:

> ***A.5 Support patients in caring for themselves to improve and maintain their own health and wellbeing.***
>
> *1. Supporting patients in caring for themselves may include:*
>
> *1.1 advising them on the effects of their life choices and lifestyle on their health and well-being*
>
> *1.2 supporting them in making lifestyle changes where appropriate.*
>
> *1.3 encouraging and supporting them to seek help from others, including other health professionals, or those coordinating their care, if necessary*
>
> *1.4 respecting patients' decisions about their care, even if you disagree with those decisions.*

102. Having reflected on potential overlap or duplication between C6 and A5, it is considered that the two standards, whilst similar to an extent, do have separate aims. A5 is centred around individual patients, whereas C6 acknowledges the role of osteopathy as a regulated health care profession in relation to the health of the community. It would seem detrimental to the role of osteopathy to remove C6 and rely just on A5 to reflect this.

103. The Stakeholder Reference Group discussed this issue at length. It was agreed that the iO's suggestion as to the rewording of the standard was helpful, and would, it is hoped, mitigate some of the concerns raised during the consultation. It was felt that the word 'provider', should be replaced with 'professional', however, and that some reference should be made to the wider role of osteopaths.

104. Subsequently, the Executive reflected on the reference to 'social' wellbeing within the iO's suggestion (which was an adaptation of an NMC standard relating to midwifery). On balance, it was felt that the original midwifery context for this was more explicit than the Osteopathic Practice Standards in terms of the social context, referencing public health policies, groups with particular needs and local communities for example. As a consequence, it is felt that the suggested updated C6 would be more clear if reference to 'social wellbeing' was replaced by just 'wellbeing'.

**Proposed approach**

Largely accept the iO suggestion to change the wording of the standard (with modifications) to: *'You must be aware of your wider role as a healthcare professional to contribute to enhancing the health and wellbeing of your patients'.*

Retain the current draft guidance but for a slight amendment (changing 'impartial' to 'in a balanced way':

1. You should be aware of public health issues and concerns, and be able to discuss these in a balanced way with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these.

*General comments*

105. One respondent commented that the document places little emphasis on evidence-based practice, other than in C1.1.4.

106. Standard C1 relates to the ability to conduct an osteopathic patient evaluation and deliver safe, competent and appropriate osteopathic care. The guidance in C1.1.4 indicates that this should include the ability to:

*"develop and apply an appropriate plan of treatment and care. This should be based on:*

*i. the working diagnosis*

*ii. the best available evidence*

*iii. the patient's values and preferences*

*iv. your own skills, experience and competence."*

107. It is felt that this guidance does sufficiently encapsulate the nature of evidence based practice, as outlined by Sackett et al in 1996[13]:

*"Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care."*

[13] http://www.dcscience.net/sackett-BMJ-1996.pdf

108. The respondent went on to reference 'craniosacral therapy' as something practiced by some osteopaths for which '*there is good evidence that this doesn't work*', and which prevents osteopathy being regarded as a legitimate profession. It is understood that there are areas within osteopathic practice where the evidence is sparse, and the GOsC does not envisage enforcing or prohibiting the use of commonly used approaches, provided the standards are adhered to.

109. One respondent queried reference to 'osteopathic' evaluation in C1, and put this in the context of working as an osteopath within the NHS. They gave an example of carrying out a standard neurological/orthopaedic exam on a patient and referring them for an MRI scan, and queried whether this would be regarded as 'osteopathic', particularly if contrasted with the patient's previous experience of osteopathic treatment.

110. In response to this point, it is considered that there would be a contextual element to the interpretation of the standard. If an osteopath was working in an NHS context, then the expectations of this role would also be a factor in determining how the standards would be implemented. On this basis, it is considered that the wording is not inconsistent with practice in such a setting. The standard would also not be applied in isolation – the practitioner's role, and the patient's expectations around this and options for care should all be discussed as outlined in other standards, and consent gained.

## D. Professionalism

*Standard D1 – acting with honesty and integrity*

111. There were several comments made relating to this standard. One called for clarity about what was meant by honesty and integrity. Another pointed out that the wording at the start of D1.2 is slightly misleading, as it starts with 'Allowing misleading advertising and information……' Another suggested that referring to the ASA guidance meant that if ever the ASA ceased to be the body responsible for this, then the guidance would need review.

112. Although there were few comments made regarding advertising during the consultation, it is worth mentioning that a number of osteopaths have emailed since raising concerns around this, prompted by a particular case. Typically, these are along the following lines:

    *"There is apparently no justification why you are outsourcing to the ASA for guidance, nor it seems are the ASA and CAP code able to provide transparent or robust evidence for their opinions. I believe the standard D1: 2.1 must been removed as it seems to have no basis for its inclusion:*

    *The revised Osteopathic Practice Standard D1: 2.1 connection to the CAP Code is unacceptable. The direct connection of OPS to the CAP Code and ASA must be removed. The proposal: "You should make sure that … your advertising*

*and promotional material, including website content, conforms to current guidance, such as the UK code of non-broadcast advertising, Sales Promotion and Direct Marketing (the CAP Code)" must be deleted."*

113. One respondent made a point regarding D1.2.3 which says that osteopaths should not use a title which implies they are a medical practitioner unless they are a registered medical practitioner. The respondent suggested that this should refer instead to those with a medical degree *eligible* for registration with the GMC, rather than having to be licenced to practice medicine.

*Discussion*

114. In terms of the definition of honesty and integrity, the guidance is intended to provide examples of this. This is worded around examples as to what a lack of integrity might look like, however, rather than honesty. A recent High Court case[14] in relation to a solicitor's appeal against being struck off by the Solicitors Disciplinary Tribunal ruled that a lack of integrity was 'not synonymous' with dishonesty. For conduct to be dishonest in solicitors disciplinary proceedings, the behaviour must be found to be dishonest '*by the standards of reasonable and honest people'*, and the solicitor must realise that they are dishonest. In relation to a lack of integrity, there is no requirement that the solicitor must realise subjectively that their conduct lacks integrity. Case law established that integrity denoted '*moral soundness, rectitude and steady adherence to an ethical code*'. A person may lack integrity, even though not established as being dishonest. It is suggested that these concepts might be explained and explored in case studies, and resources.

115. As to the wording of D1.2, it is agreed, on reflection, that this is ambiguous.

116. As to the comments received subsequent to the consultation regarding advertising referenced in standard D1.2.1, the law around this is clear. Under the terms of *the Consumer Protection from Unfair Trading Regulations 2008* it is considered 'unfair' to falsely claim that a product (or service) is 'able to cure illnesses, dysfunction or malformations'. The Advertising Standards Authority (ASA) is an independent body which regulates implementation of the law concerning advertising. Osteopaths, as healthcare providers, are subject to the remit of the ASA alongside any other providers of goods and services.

117. The GOsC has received some 400 concerns around advertising within the last two years. Its approach to managing these has been to encourage compliance with ASA requirements, which for most has led to the concern being satisfactorily resolved. In the event that an osteopath fails to comply with the requirements of the ASA, this may then be considered by the GOsC to be a potential breach of the *Osteopathic Practice Standards* (current D17 states 'uphold the reputation of the profession through your conduct').

[14] https://www.legalfutures.co.uk/latest-news/solicitor-can-lack-integrity-without-dishonest-says-high-court

118. On the issue of medical practitioners using the title 'doctor', this was discussed with the Stakeholder Reference Group. The consensus was that osteopaths should be very clear to patients and others as to the rationale for using the title 'Doctor'. Having a registerable qualification, or even being registered without a licence to practice, was not enough to justify calling oneself a doctor without being completely clear as to the implications of this.

**Proposed approach**

Amend D1.2 to; "*You should not allow misleading advertising or information about you and your practice. You should make sure that*:……"

Retain D1.2.1 regarding advertising as drafted.

Amend D1.2.3 to: *You do not use any title that implies you are a licensed medical practitioner if you are not. If you use the title 'Doctor' because you have a PhD or other doctorate, or you are a medical doctor but you do not have a licence to practise, you should make it clear to patients and others the basis on which you are using the title.*

Consider the need to develop learning resources/case studies in honesty and integrity to help support the implementation of the standard in practice (along the lines of the case studies used to illustrate the joint statement on conflicts of interest[15])

*Standard D2 – Professional boundaries*

119. This standard has been updated to require osteopaths to establish and maintain clear professional boundaries with patients, and not to abuse their professional standing and position of trust. Question 9 asked whether the updated guidance and its guidance are clear and easy to use. There were 132 responses, of which 114 (86%) felt that this was the case.

120. Some queried the new D2.5.7 which states that osteopaths should not end a professional relationship with a patient solely to pursue a personal relationship with them. Some thought that ending a professional relationship was the appropriate way of managing such a situation, and that consenting adults should be free to establish personal relationships if they wished.

121. One respondent thought that D2.5.6 which says '*you must not take advantage of your professional standing to initiate a personal relationship with your patient'*, would preclude any form of personal relationship along the lines of those acknowledged in D2.5.9.

[15] Available at: http://www.osteopathy.org.uk/standards/guidance-for-osteopaths/conflicts-of-interest/

122. One pointed out that friendships can develop with patients, particularly those who work in a particular capacity such as sports or the performing arts, where there is frequent contact. There is a need to be clear as to when this is acceptable.

123. Another respondent indicated that although the guidance refers to social and sexual relationships, there was nothing mentioned about commercial relationships; for example, using a patient who is a trades person of some kind to undertake work.

*Discussion*

124. In relation to D2.5.7 the guidance that osteopaths should not end a professional relationship with a patient solely to pursue a personal relationship with them, is consistent with advice given to doctors by the General Medical Council[16].

125. Regarding D2.5.6, the issue is not that personal relationships of some kind with patients are forbidden, as is acknowledged in D2.5.9. The point is that an osteopath *must not take advantage of their professional standing* to instigate such a relationship. This relates to the power imbalance inherent in therapeutic relationships, and the fact that this must not be exploited to fulfil the emotional and social needs of the practitioner.

126. In the case of friendships with patients when working in small communities or specialised areas of practice, this is covered to an extent in D2.5.9 which acknowledges that osteopaths who practice in small communities may find themselves treating friends or family. This refers to osteopaths in these circumstances finding themselves having friends or family who become patients, but does not reference patients becoming friends, which might also occur in a small community, whether that's a town, village or workplace, for example.

127. With reference to commercial relationships with patients, this is a valid point, and could be addressed by referencing commercial, as well as social relationships in D2.4.

128. Stakeholder Reference Group members provided further feedback on this section, including around the use of language, and some subsequent amendments to D2 and its guidance are set out in the appendix to this document.

[16] https://www.gmc-uk.org/Maintaining_a_professional_boundary_between_you_and_your_patient.pdf_58833579.pdf

**Proposed approach**

Amend first sentence of D2.4 to:

*You should be aware of the risks to patients and to yourself of engaging in or developing social or commercial relationships with patients, and the challenges which this might present for the therapeutic relationship and to the expectations of both patient and professional.*

Amend D2.5.2 to refer to a sexual response, rather than just a relationship:

*You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship or response.*

Other minor editorial changes are set out in the appendix to this document.

*Standard D3 – Duty of candour*

129. This is a new standard which requires osteopaths to be open and honest with patients and fulfil their duty of candour. The guidance reflects the joint statement on candour signed by the chief executives of all UK healthcare regulators[17]. Question 10 asked whether this was sufficiently clear and easy to use. There were 125 responses, of which 113 (90%) felt that this was the case.

130. Some queried whether there was a tension between the duty of candour and admitting liability, and how this could be balanced with insurers.

131. One respondent pointed out that starting D3.2 with 'where appropriate' might give the impression that there are times when it is appropriate not to also be open and honest with colleagues or employers.

*Discussion*

132. In relation to tensions between fulfilling the duty of candour and a reluctance to 'admit liability', this would need to be managed in whatever circumstances arose. The standard reflects the expectations in this respect of all UK healthcare professionals, and all will be in a similar situation. It's really about being open and honest with patients when something has gone wrong or has the potential to cause harm or distress, and it is difficult to envisage any circumstances when this would not be the right thing to do.

[17] http://www.osteopathy.org.uk/standards/osteopathic-practice/duty-of-candour/

133. With regard to D3.2, the 'where appropriate' was intended as an acknowledgement of the fact that many osteopaths work alone, and do not have employers. The point made about this potentially implying that even where there are colleagues or employers, it might be appropriate not to be honest with them is a valid one, however, and it is suggested that these words be deleted.

**Proposed approach**

Amend D3.2 to '*You must also be open and honest with your colleagues and/or employers, where applicable, and take part in reviews and investigations when requested*.'

*Standard D5 – management of patient information*

134. Standard D5 has been updated from its current form (D6 in the current OPS) to also require osteopaths to effectively maintain and protect patient information. Question 11 asked whether the updated standard and guidance were sufficiently clear and easy to use. There were 126 responses to this, with 118 (94%) agreeing that this was the case.

135. Some of the comments from those who did not think the standard and guidance were clear centred around procedures for retaining patient records, and how these should be communicated to patients. Similarly, regarding what steps should be taken if a practice is sold, or an osteopath stops practicing, retires or dies.

136. One suggested amending D5.5 to include 'safely *and securely*' to assure confidence in the procedure.

137. One made a point in relation to D5.7.5 which says 'disclose only the information you need to' in relation to disclosure of confidential information, and queried whether this might conflict with the requirements of insurers (AXA PPP for example) who require full records.

*Discussion*

138. The queries around policies and procedures for retaining and destroying patient records, or for informing patients when practices are sold or the osteopath stops practicing for whatever reason, highlight that these are not always well understood. There is only so much that can be included within a standards document around this, but it is an area where further resources might be developed to support osteopaths in meeting the standard appropriately.

139. In relation to D5.5, the addition of '..and securely' seems appropriate in the circumstances. The Oxford Dictionary defines safely as 'in a way that gives

protection from danger or risk', and securely as 'in a fixed or stable manner/without threat or danger'. They may be synonymous, but could also be seen as complementary.

140. With regard to the point concerning D5.7.5, it is considered that such circumstances could be managed within the wording as it stands without further amendment.

**Proposed approach**

Amend D5.5 to '….continue to be kept safely and securely…'

*Standard D10 – position of osteopathy in relation to other healthcare providers*

141. This standard and its guidance were modified to emphasise an understanding of the contribution of osteopathy within the context of healthcare as a whole. Question 12 asked whether this was clear and adequately sets out this position. There were 121 responses, of which 110 (91%) agreed that this was the case.

142. One respondent raised a query as to whether 'understand' was the right word in the context of D10.2 (now renumbered to 10.1.2), whether 'have an appreciation' would better reflect the intent, and how would this standard be evaluated.

143. Another respondent wondered whether mention needed to be made if there was a conflict of opinion between healthcare providers.

*Discussion*

144. With regard to D10.1.2, it is considered that 'understand the contribution of osteopathy within the context of healthcare as a whole' is appropriate wording for what is, in fact, guidance as to how the actual standard should be implemented.

145. With regard to conflicts of opinion, although these are not specifically referenced, the guidance indicates that other health and care professionals should be treated with respect, and that osteopaths should work collaboratively with others where such approaches are available. Within this context, differences of opinion should be manageable without spelling out each scenario.

**Proposed approach**

Accept the standard and guidance as drafted (subject to a slight modification of the guidance numbering for consistency).

*Equality impact*

146. Question 16 asked whether there any aspects of the proposed updated Osteopathic Practice Standards that respondents 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.

147. 109 respondents answered this question, of which 93% indicated that they did not think there were any such aspects.

148. Some respondents made comments about characteristics which are not protected under the Equality Act 2010, such as personality types, or those in part-time work.

149. One suggested additional resources around ethnic diversity and cultural expectations might be useful, though referenced this in the context of undergraduate education.

150. One suggested that there might be an impact on those unable to give consent as they lack capacity, and that there should be guidance to deal with this patient group. They also suggested that further guidance should be given for osteopaths to evaluate an individual's capacity, and for dealing with those with protected characteristics such as gender issues or learning disabilities.

151. Another respondent suggested that anything in a written format has the potential to adversely affect osteopaths with dyslexia, for example, or for whom English is not their first language.

*Discussion*

152. The comments indicate a potential need for further guidance and resources to support osteopaths in meeting the needs of patients with particular needs or protected characteristics. Also to consider enhancing the accessibility of the document to osteopaths who might prefer a non-written version of the standards.

153. The LGBT Foundation offer a 'Pride in Practice' accreditation for primary care practitioners. The General Pharmaceutical Council[18] promote this for their registrants using a case scenario, and the General Medical Council offers guidance[19] to doctors treating trans patients.

[18] https://www.pharmacyregulation.org/regulate/article/focus-pride-practice

[19] https://www.gmc-uk.org/guidance/28851.asp

**Proposed approach**

Consider production of an audio version of the *Osteopathic Practice Standards* as part of the implementation process.

Consider development of resources to support osteopaths in meeting their requirements under the standards in terms of equality.

General Osteopathic Council

**Appendix – Post consultation revisions to updated *Osteopathic Practice Standards***

This table summarises changes made to the consultation version of the *Osteopathic Practice Standards.* In each case, the consultation version of the standard and/or associated guidance is shown in the left column, the changes are shown in the centre, and the rationale is set out on the right. Where appropriate, amendments are highlighted in yellow. The changes reflect issues raised in response to the consultation, input from the *Stakeholder Reference Group,* and further reflection and consideration by the GOsC executive team. In most cases, amendments are editorial, aimed at improving wording and clarifying meaning, without altering the intent of the original wording.

| **Communication and patient partnership** | | |
|---|---|---|
| **Consultation version standard/guidance** | **Proposed change** | **Rationale** |
| A1 Listen to patients and respect their individuality, concerns and preferences. You must be polite and considerate with patients, and treat them with dignity and courtesy. | A1 You must listen to patients and respect their individuality, concerns and preferences. You must be polite and considerate with patients, and treat them with dignity and courtesy. | It was pointed out that there was an inconsistency with some standards starting with 'you must' and some not. There are some options; 1. to remove 'you must' from all standards, though in some instances this did not work well; 2. Have an overarching 'You must' at the start of each theme, though again, this did not always work |

| | | |
|---|---|---|
| | | effectively when it came to referring to individual standards; 3. Add 'You must' to all standards. We have chosen option 3 for consistency. |
| A1.1 Poor communication is at the root of most patient complaints. Effective communication is a two-way exchange, which involves not just talking but also listening with care. Patients may be anxious and vulnerable, and will come to you with different experiences and expectations. | A1.1 Poor communication is at the root of most patient complaints. Effective communication is a two-way exchange, which involves not just talking but also listening with care. | Some slight modifications to A1 guidance to improve the language in parts, and to avoid repetition. |
| A1.2. You should be alert to patients' unspoken signals; for example, when a patient's body language or tone of voice indicates that they may be uneasy or experiencing discomfort. | A1.2 You should be alert to patients' unspoken signals; for example, when a patient's body language or tone of voice indicates that they may be uneasy, experiencing discomfort or anxious and vulnerable. | |
| A1.3 Patients will come to you with different experiences and expectations. You should try to accommodate their wishes as much as you can without compromising the care you provide. If you cannot accommodate their wishes you should explain why to the patient. | A1.3 Patients will come to you with different experiences and expectations. You should try to accommodate their wishes as much as you can without compromising the care you can provide. If you cannot accommodate their wishes you should explain why you are unable to do so. | |
| A1.4 Be aware that patients will also have particular needs or values in relation to gender, ethnicity, culture, religion, belief, sexual orientation, lifestyle, age, social | A1.4 Be aware that patients will also have particular needs or values in relation to gender, ethnicity, culture, religion, belief, sexual orientation, lifestyle, age, social status, language, | |

| | | |
|---|---|---|
| status, language, physical and mental health and disability. You must be able to respond appropriately to these needs. | physical and mental health and disability. You must be able to respond respectfully and appropriately to these needs. | |
| A2.1 Trust is an essential part of a clinical relationship, and can only be developed through effective communication between an osteopath and their patient. | A2.1 Trust is an essential part of a clinical relationship, and requires effective communication between osteopath and patient. | These are some slight amendments to A2.1, A2.2 and A2.4 to improve the way they read.<br><br>A2.1 – changed 'can only be developed through' to 'requires'.<br><br>In A2.2, at one respondent's suggestion, we have changed reference to 'condition' to 'symptoms'.<br><br>We have changed 'self-care' in A2.5.2 to 'ways to support their own health. |
| A2.2 You must care for your patients and do your best to understand their condition and improve their health. | A2.2 You must care for your patients and do your best to understand their symptoms and support their health. | |
| A2.4 You should share with patients accurate and relevant information and encourage them to ask questions and to take an active part in decisions about their treatment and care. | A2.4 You should share accurate and relevant information with patients, encourage them to ask questions, and to take an active part in decisions about their treatment and care | |
| A2.5 The most appropriate treatment for patients will sometimes involve:<br>5.1 referring them to another osteopath or other healthcare professional<br>5.2 providing advice on self-care<br>5.3 not treating them at all | 5.2 providing advice on ways to support their own health. | |
| A3 Give patients the information they want or need to know in a way they can | A3. You must give patients the information they want or need to know in a way they can | Added 'You must' for consistency. |

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| understand. | understand. | |
| A3.2 Inform your patients of any material or significant risks associated with the treatment you are proposing, as well as anticipated benefits, and confirm their understanding of these. If you are proposing no treatment, you should explain potential risks associated with this. You should discuss care options and encourage patients to ask questions, and deal with these clearly, fully and honestly. | A3.2 You should discuss care options, encourage patients to ask questions, and deal with these clearly, fully and honestly. You should inform your patients of anticipated benefits and any material or significant risks associated with the treatment you are proposing, and confirm their understanding of these. If proposing no treatment, you should explain any potential risks and benefits associated with this. | Reordered this to emphasise the discussion first. |
| A4.1 Gaining consent is a fundamental part of your practice and is both an ethical and legal requirement. If you examine or treat a patient without their consent, you may face criminal, civil or GOsC proceedings. | A4.1 Gaining consent is a fundamental part of your practice and is both an ethical and legal requirement. If you examine or treat a patient without consent, you may face criminal, civil or GOsC proceedings. | Taken out 'their'. |
| A4.2 The gaining of consent is an ongoing process. You must ensure that patients are able to make decisions at all stages of their treatment and care, and continue to give consent. | A4.2 Gaining consent is an ongoing process. You must ensure that patients are able to make decisions at all stages of their treatment and care, and continue to give consent. | Changed 'the gaining of' to just 'Gaining'. |
| A4.4 To be voluntary, the patient must not be under any form of pressure or undue influence to consent to osteopathic care. You must ensure that patients are given the information they need in order to give their consent, and to reach their own decision on | A4.4 To be voluntary, the patient must not be under any form of pressure or undue influence to consent to osteopathic care. You must ensure that patients are given the information they need to reach their own decision and give consent. | Improved the wording |

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| this. | | |
| A4.6 The patient needs to understand the nature, purpose, benefits and risks of the examination or treatment proposed. The patient must then be free to either accept or refuse the proposed examination or treatment. Some patients may need time to reflect on what you have proposed before they give their consent to it. | A4.6 The patient needs to understand the nature, purpose, benefits and material or significant risks to them of the examination or treatment proposed. The patient must then be free to either accept or refuse the proposed examination or treatment. Some patients may need time to reflect on what you have proposed before they give their consent to it. | Added material and significant in the context of risks, and referred and emphasised these are risks to the patient. |
| A4.8 Before relying on a patient's consent, you should consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed. | A4.8 Before deciding that consent has been given, you should consider whether patients have been given the information they want or need, and how well they understand the details and implications of what is proposed. | Changed 'relying on a patient's consent' to 'deciding that consent has been given'. |
| A4.10 Capacity, in this context, relates to the ability of an individual to understand, retain and evaluate information to make a decision regarding their health needs and treatment options, and to communicate this. | A4.10 Capacity, in this context, relates to the ability of an individual to understand, retain and evaluate information and to make and communicate a decision regarding their health needs and treatment options. | Improved wording |
| A4.11 You must not assume that a patient lacks capacity solely because of their age, disability, appearance, behaviour, medical condition, beliefs, or because they make a decision which you disagree with. The starting point should always be a | A4.11You must not assume that a patient lacks capacity solely because of their age, disability, appearance, behaviour, medical condition, beliefs, or because they make a decision with which you disagree. The starting point should always be a presumption of capacity. | Minor change – 'which you disagree with' to 'with which you disagree'. |

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| presumption of capacity. | | |
| A4.15 A child may have the capacity to consent, depending on their maturity and ability to understand what is involved. You will need to apply the law, and use your professional judgement in assessing the capacity of each patient under 16 years. You are strongly advised to involve a person with parental responsibility for the child when seeking consent. | A4.15 A child may have the capacity to consent. You will need to apply the law, and use your professional judgement in assessing the capacity of each patient under16 years, which will depend on their maturity and ability to understand what is involved. You are strongly advised to involve a person with parental responsibility for the child when seeking consent. | Slight rewording. |
| A4.17 A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing for them because, as with adults, consent must be valid. | A4.17 A young person can be treated as an adult and can be presumed to have the ability to make decisions about their own care. Nevertheless, you will need to use your professional judgement to assess whether the young person in fact has the maturity and ability to understand what is involved in the treatment you are proposing, because, as with adults, consent must be valid. | Deleted 'for them' |
| A4.20 Valid consent does not always have to be in writing. However, if you are proposing a vaginal or rectal examination or technique, written consent must be obtained and kept with the patient records. You may also consider gaining written consent for other procedures, particularly those relating to areas which the patient | A4.20 Valid consent does not always have to be given in writing by the patient. However, if you are proposing a vaginal or rectal examination or technique, written consent must be obtained and kept with the patient records. You may also consider gaining written consent for other procedures, particularly those relating to areas | Clarified it doesn't have to be given in *writing by the patient* |

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| considers intimate. | which the patient considers intimate. | |
| A5. Support patients in caring for themselves to improve and maintain their own health and wellbeing. | A5. You must support patients in caring for themselves to improve and maintain their own health and wellbeing. | Added 'You must' for consistency. |
| A5. Supporting patients in caring for themselves may include:<br>1.1 advising them on the effects of their life choices and lifestyle on their health and well-being, | 1.1 providing information on the effects of their life choices and lifestyle on their health and well-being, | changed 'advising' to 'providing information on'. |
| A5.1.2 supporting them in making lifestyle changes where appropriate, | 1.2 supporting decision making about lifestyle changes where appropriate, | Changed to 'supporting decision making…' to avoid referring to 'them'. |
| A5.1.3 encouraging and supporting them to seek help from others, including other health professionals, or those coordinating their care, if necessary, | 1.3 encouraging and supporting patients to seek help from others, including other health professionals, or those coordinating their care, if necessary, | Changed 'them' to 'patients'. |
| A6 Respect your patients' dignity and modesty.<br><br>1. Patients will have different requirements as to what they need to maintain their dignity and modesty during a consultation, and you must be sensitive to these. Some of these ideas may have been shaped by a patient's | A6. You must respect your patients' dignity and modesty.<br><br>1. Patients will have different requirements for maintaining their dignity and modesty during a consultation, and you must be sensitive to these. Some of these ideas may have been shaped by a patient's culture or religion, but it is unwise to make assumptions about any | Added 'You must' for consistency.<br><br>1. Reworded to improve the paragraph. |

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| culture or religion, but it is unwise to make assumptions about any patient's ideas of modesty. | patient's ideas of modesty. | |
| A6.2.4 Giving patients the option of covering areas of their body that do not need to be exposed for examination or treatment. This can be achieved by providing the patient with a suitable gown or cover, asking that they only remove such items of clothing that are necessary for the proposed examination or treatment, or providing the opportunity to get dressed again in full or part as appropriate. If you feel it is necessary for the examination or treatment that the patient is undressed to their underwear, you should explain this to the patient, and seek their consent. | A6.2.4 Giving patients the option of covering areas of their body that do not need to be exposed for examination or treatment. This can be achieved by providing a suitable gown or cover, asking that they only remove such items of clothing that are necessary for the proposed examination or treatment, or providing the opportunity to get dressed again in full or part as appropriate. If you feel it is necessary for the examination or treatment that the patient is undressed to their underwear, you should explain this to the patient, and seek their consent. | Deleted providing '*the patient with'* |
| A6.8 If a chaperone is present, you should record this in the patient records. If a patient within one of the categories in paragraph 5 declines the offer of a chaperone, you should record this in the notes. | A6.8. If a chaperone is present, you should record this in the patient records. If a patient within one of the categories in paragraph A6.5 declines the offer of a chaperone, you should record this in the patient's notes. | 8. Corrected reference to A6.5 and specified 'patient's notes'. |
| A7.1 The same quality of service and care should be provided to all patients. It is illegal to refuse a service to someone on the grounds of their gender, ethnicity, disability, | A7.1 The same quality of service and care should be provided to all patients. It is illegal to refuse a service to someone on the grounds of their age, gender reassignment, marriage or civil | Put the list of protected characteristics in alphabetical order so as not to imply a hierarchy within these. |

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| religion or belief, sexual orientation, transgender status, age, marital or civil partnership status or pregnancy. | partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation. You should maintain a professional manner at all times, even where a personal incompatibility arises with a patient. | |
| A7.3 You are not obliged to accept any individual as a patient (subject to the points raised in paragraph 1 above), but if having done so you feel you cannot continue to give them the good quality care to which they are entitled, you may decline to continue treating them. In that case, you should try to refer them to another osteopath or healthcare professional where appropriate. Reasons for not accepting someone as a patient or declining to continue their care might include:<br>3.1 they are or become aggressive<br>3.2 they seem to have no confidence in the care you are providing<br>3.3 they appear to have become inappropriately dependent on you. | A7.3 You are not obliged to accept any individual as a patient (subject to the points raised in paragraph 1 above), but if having done so you feel you cannot continue to provide good quality care to which they are entitled, you may decline to continue treating them. In that case, you should try to refer them to another osteopath or healthcare professional where appropriate. Reasons for not accepting someone as a patient or declining to continue their care might include:<br>3.1. Aggressiveness<br>3.2. A lack of confidence in the care you are providing.<br>3.3. Inappropriate dependence on you. | Changed 'give them' to 'provide'.<br>Modified the wording in 3.1-3.3 to read better. |

| Knowledge, skills and performance | | |
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| B1. You must have sufficient and appropriate knowledge and skills to support your work as an osteopath | B1. You must have and be able to apply sufficient and appropriate knowledge and skills to support your work as an osteopath | Following stakeholder reference group input, added 'and be able to apply', to broaden the scope of this beyond just 'having' knowledge and skills. |
| B1.1.2 an understanding of osteopathic philosophy, principles and concepts of health, illness and disease, and the ability to apply this knowledge critically, in the care of patients | Becomes B1.1.1 | This remains as drafted in the consultation, but post stakeholder reference group has been moved to the top of the guidance so is now B1.1.1 |
| B1.1.5 an awareness of the principles and applications of scientific enquiry and the ability to critically evaluate data to inform osteopathic care | B1.1.5 an awareness of the principles and applications of scientific enquiry and the ability to critically evaluate scientific information and data to inform osteopathic care | Have added 'scientifc information and…' |
| B1.1.9 the ability to determine clinical changes by the appropriate use of observation, palpation and motion evaluation | B1.1.9 the ability to determine changes in health and function by the appropriate use of observation, palpation, motion and clinical evaluation | Amended 'clinical changes' to 'changes in health and function', and added reference to clinical evaluation. |
| B2.1 You should use your professional judgement to assess whether you have the training, skills and competence to treat a patient. | B2.1 You should use your professional judgement to assess whether you have the training, skills and competence to treat a patient, seeking advice where necessary. | Added 'seeking advice where necessary' to emphasise this aspect to decision making. |
| To achieve this, you should:<br>1. Be professionally engaged, undertaking professional development activities, and complying with GOsC requirements | 1 To achieve this, you should:<br>1.1 Be professionally engaged, undertaking professional development activities, and complying with GOsC requirements | Modified numbering of guidance paragraphs.<br><br>Added reference to 'research' in 1.2.3 |

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| regarding continuing professional development.<br><br>2. Keep up-to-date with factors relevant to your practice, including:<br>2.1 GOsC guidance<br>2.2 legal requirements or changes to the law in relation to your practice, for example, in relation to data storage (see standard C3), health and safety in the workplace (see standard C5) and equality issues (see standard D6)<br>2.3 other relevant developments in healthcare. | regarding continuing professional development.<br><br>1.2 Keep up-to-date with factors relevant to your practice, including:<br>1.2.1 GOsC guidance<br>1.2.2 legal requirements or changes to the law in relation to your practice, for example, in relation to data storage (see standard C3), health and safety in the workplace (see standard C5) and equality issues (see standard D6)<br>1.2.3 research and other relevant developments in healthcare. | |
| B4.1 To achieve this you will need to have sufficient knowledge and ability to collect and analyse evidence about your practice to support both patient care and your own professional development. | B4.1 To achieve this you will need to have sufficient knowledge and ability to collect and analyse information and evidence about your practice to support both patient care and your own professional development. | Added reference to 'information' as well as 'evidence about your practice'. |
| **Safety and quality in practice** | | |
| Opening paragraph:<br><br>Osteopaths must deliver high-quality and safe healthcare to patients. This theme sets out the standards in relation the delivery of | Osteopaths must deliver high-quality and safe healthcare to patients. This theme sets out the standards in relation the delivery of care, | Retained 'public health' reference, but deleted |

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| care, including evaluation and management approaches, record keeping, safeguarding of patients and the promotion of public health. | including evaluation and management approaches, record keeping, safeguarding of patients and public health. | 'promotion of'. |
| C1.1:<br><br>1. This should include the ability to:<br>1.1 take and record the patient's case history, adapting your communication style to take account of the patient's individual needs and sensitivities<br><br>1.2 select and undertake appropriate clinical assessment of your patient, taking into account the nature of their presentation and their case history<br><br>1.3 formulate an appropriate working diagnosis or rationale for care, and explain this clearly to the patient<br><br>1.4 develop and apply an appropriate plan of treatment and care. This should be based on:<br>1.4.1 the working diagnosis<br><br>1.4.2 the best available evidence<br><br>1.4.3 the patient's values and preferences<br><br>1.4.4 your own skills, experience and competence. | C1.1<br><br>1. This should include the ability to:<br>1.1 take and record the patient's case history, adapting your communication style to take account of the patient's individual needs and sensitivities,<br><br>1.2 select and undertake appropriate clinical assessment of your patient, taking into account the nature of their presentation and their case history,<br><br>1.3 formulate an appropriate working diagnosis or rationale for care, and explain this clearly to the patient,<br><br>1.4 develop and apply an appropriate plan of treatment and care. This should be based on:<br>1.4.1 the working diagnosis<br>1.4.2 the best available evidence<br>1.4.3 the patient's values and preferences<br>1.4.4 your own skills, experience and competence,<br><br>1.5 adapt an osteopathic technique or treatment | Same content but slight reordering |

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| 1.5 monitor the effects of your care, and keep this under review. You should cease care if requested by the patient or if you judge that care is likely to be ineffective or not in the patient's best interests<br><br>1.6 adapt an osteopathic technique or treatment approach in response to findings from palpatory examination<br><br>1.7 evaluate post-treatment response and justify the decision to continue, modify or cease osteopathic treatment as appropriate<br><br>1.8 recognise adverse reactions to treatment, and take appropriate action<br><br>1.9 recognise when errors have been made, and take appropriate action to remedy these, taking account of the patient's best interests under your duty of candour (see D3)<br><br>1.10 where appropriate, you should refer the patient to another healthcare professional, following appropriate referral procedures. | approach in response to findings from the examination of your patient<br><br>1.6 evaluate post-treatment response and justify the decision to continue, modify or cease osteopathic treatment as appropriate,<br><br>1.7 recognise adverse reactions to treatment, and take appropriate action,<br><br>1.8 monitor the effects of your care, and keep this under review. You should cease care if requested by the patient or if you judge that care is likely to be ineffective or not in the patient's best interests,<br><br>1.9 recognise when errors have been made, and take appropriate action to remedy these, taking account of the patient's best interests under your duty of candour (see D3), where appropriate, refer the patient to another healthcare professional, following appropriate referral procedures. | |
| C1.2 If providing care outside of your usual practice environment, you should note in your records where this took place, and apply the same standards, where possible, | C1.2 If providing care outside of your usual practice environment, you should note in your records where this took place, and apply the same standards, as you would apply in your usual | Added further reference here to being able to justify professional judgment in this regard. |

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| as you would apply in your usual practice | practice, or be able to justify why this was not appropriate. | |
| C2 Ensure that your patient records are full, accurate, legible and completed promptly. | C2 You must ensure that your patient records are comprehensive, accurate, legible and completed promptly. | Added 'You must', and changed 'full' to comprehensive'. |
| C2.1 Records that are accurate, comprehensive and easily understood will help you provide good care to your patients. These records should include:<br>1.1 date of the consultation<br>1.2 patient's personal details<br>1.3 any problems and symptoms reported by your patient<br>1.4 relevant medical, family and social history<br>1.5 your clinical findings<br>1.6 the information and advice you provide, and how this is provided<br>1.7 a working diagnosis and treatment plan<br>1.8 records of consent<br>1.9 any treatment you undertake<br>1.10 any communication with, about or | C2.1 Records help you to provide good quality care to your patients, and should include:<br>1.1 date of the consultation<br>1.2 patient's personal details<br>1.3 any problems, symptoms, concerns and priorities discussed with your patient,<br>1.4 relevant medical, family and social history,<br>1.5 your clinical findings,<br>1.6 the information and advice you provide, including a record of how this is communicated to your patient,<br>1.7 a working diagnosis and treatment plan,<br>1.8 records of consent,<br>1.9 any treatment you undertake,<br>1.10 any communication with, or about the patient<br>1.11 copies of any correspondence, reports, test results, etc. relating to the patient | Slight amendment to tidy up the language.<br><br>Changed C2.1.16 to a separate para 2 as it didn't work as a follow on from the 'these should include' heading. |

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| from your patient<br>1.11 copies of any correspondence, reports, test results, etc. relating to the patient<br>1.12 clinical response to treatment and treatment outcomes.<br>1.13 the location of your visit if outside your usual consulting rooms<br>1.14 whether any other person was present and their status<br>1.15 where an observer is present (for example, an osteopathic student, potential student or peer observer) as well as their status and identity, you should record the patient's consent to their presence<br>1.16 your notes should be contemporaneous or completed promptly after a consultation (generally on the same day). | 1.12 clinical response to treatment and treatment outcomes.<br>1.13 the location of your visit if outside your usual consulting rooms<br>1.14 where an observer or any other person is present (for example, a chaperone, peer observer, osteopathic student, or potential student) as well as their status and identity, you should record the patient's consent to their presence.<br>2. Your notes should be contemporaneous or completed promptly after a consultation (generally on the same day).<br>3. The information you provide in reports and forms or for any other purpose associated with your practice should be honest, accurate and complete. | |
| C3 You must respond effectively and appropriately to requests for the production of written material and data.<br>To achieve this you will need to:<br>1. Be able to produce reports and referrals, and present information in an appropriate format to support | C3 You must respond effectively and appropriately to requests for the production of written material and data.<br>1. To achieve this you will need to:<br>1.1 Produce reports and referrals, and present information in an appropriate format to support patient care and effective practice | Modified numbering of the guidance paragraphs.<br>Deleted 'Be able to' from the start of C3.1.1 |

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| patient care and effective practice management.<br><br>2. Develop mechanisms for storing and retrieving patient information, including financial and other practice data to comply with legal requirements in relation to confidentiality, data processing and storage, and requests for information from patients, healthcare professionals or other authorised parties. | management.<br><br>1.2 Develop mechanisms for storing and retrieving patient information, including financial and other practice data to comply with legal requirements in relation to confidentiality, data processing and storage, and requests for information from patients, healthcare professionals or other authorised parties. | |
| C4<br><br>3.3 if the practitioner belongs to a regulated profession, reporting your concerns to their regulatory body<br><br>3.4 if the practitioner belongs to a voluntary register, reporting your concerns to that body | 3.3 if the practitioner belongs to a regulated profession, reporting your concerns to their regulator<br><br>3.4 if the practitioner belongs to a voluntary register, reporting your concerns to that organisation | A couple of minor changes to avoid 'body' in favour of 'regulator' or 'organisation'. |
| C4 | C4.6 You must comply with any mandatory reporting requirements, for example, those related to female genital mutilation (FGM) in England and Wales. | We have added this paragraph to the guidance for C4 (You must take action to keep patients from harm), to specifically reference mandatory reporting requirements such as that for FGM (though this applies only in England and Wales). |

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| C6. Be aware of your role as a healthcare provider to promote public health.<br><br>1. 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. | C6 You must be aware of your wider role as a healthcare professional to contribute to enhancing the health and wellbeing of your patients**.**<br><br>1 You should be aware of public health issues and concerns, and be able to discuss these in a balanced way with patients, or guide them to resources or to other healthcare professionals to support their decision making regarding these. | Altered following feedback and accepted the rewording of the standard suggested by the iO. Added 'You must' for consistency with other standards. iO suggested 'social wellbeing', but on reflection, we felt it best to leave it as 'health and wellbeing'. We've also emphasised the 'wider' role as a healthcare professional, rather than provider.<br><br>In the guidance, have altered 'impartially' to 'in a balanced way', in response to feedback. |

| Professionalism | | |
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| Opening statement:<br><br>Osteopaths must act with honesty and integrity and uphold high standards of professional and personal conduct to ensure public trust and confidence in the profession. The standards in this theme deal with such issues and behaviours, including the establishment of clear professional boundaries with patients, the duty of candour, and the confidential management of patient information. | Osteopaths must act with honesty and integrity and uphold high standards of professional and personal conduct to ensure public trust and confidence in the profession. The standards in this theme deal with such issues and behaviours, including the establishment of clear professional boundaries with patients, the duty of candour, and the confidential management of patient information. These contribute to ensure that trust is established and maintained within therapeutic relationships. | Added an extra line to reference trust in therapeutic relationships. |
| D1.1.5 This currently states, as an example of a lack of integrity:<br><br>'accepting referral fees'. | 'accepting referral fees' has now been deleted. | It was considered that accepting referral fees is not, in itself, an example of a lack of integrity. The issue would be non-disclosure of this, and this is already sufficiently dealt with under D8.5 (see below). |
| D1.2 Allowing misleading advertising or information about you and your practice. You should make sure that: | D1.2 You should not allow misleading advertising or information about you and your practice. You should make sure that: | The original wording was grammatically unclear. |
| D1.2.3 You do not use any title that implies you are a medical practitioner (unless you are a registered medical practitioner). This does not prevent you from using the title 'Doctor' if you have a PhD or other doctorate and it is clear that | D1.2.3 You do not use any title that implies you are a licensed medical practitioner if you are not. If you use the title 'Doctor' because you have a PhD or other doctorate, or you qualified as a medical doctor but you do not have a licence to practise, you | Modified the wording to emphasise clarity around having a licence to practice, rather than just being registered (which is different). |

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| the title relates to this. | should make this clear to patients and others. | |
| D1.3 You must have a professional indemnity arrangement which provides appropriate cover. | D1.3 You must have a professional indemnity insurance arrangement which provides appropriate cover in accordance with the requirements of the Osteopaths Act and the current Professional Indemnity Insurance Rules. | Added 'insurance' and 'referenced the Osteopaths Act and the Professional Indemnity Insurance Rules. |
| D2 You must establish and maintain clear professional boundaries with patients, and must not abuse your professional standing and the position of trust which you occupy as an osteopath. | D2 You must establish and maintain clear professional boundaries with patients, and must not abuse your professional standing and the position of trust which you have as an osteopath. | Changed 'occupy' to 'have'. |
| D2.3 Not all crossing of professional boundaries will necessarily be an abuse of your professional standing. For example, sometimes it may support empathy and trust with a patient to disclose personal information or to treat a patient as an emergency outside your usual hours. However, there is a spectrum and osteopaths must ensure that patients who may be vulnerable are protected at the time and also throughout the duration of the professional relationship. | D2.3 Not all crossing of professional boundaries will necessarily be an abuse of your professional standing. For example, sometimes it may support empathy and trust with a patient to disclose personal information or to treat a patient as an emergency outside your usual hours. However, osteopaths must ensure that patients who may be vulnerable are protected at the time and also throughout the duration of the professional relationship. | Deleted 'there is a spectrum'. |
| D2.4 You should be aware of the risks to patients and to yourself of engaging in or developing social relationships with patients, and the challenges which this | D2.4 You should be aware of the risks to patients and to yourself of engaging in or developing social or commercial relationships with patients, and the challenges which this might present for the | Added reference to commercial relationships, and changed 'raise to' to 'present for'. |

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| might raise to the therapeutic relationship and to the expectations of both patient and professional. You should also be aware of the risk of patients developing an inappropriate dependency upon you, and be able to manage these situations appropriately – seeking advice from a colleague or professional body as necessary. | therapeutic relationship and to the expectations of both patient and professional. You should also be aware of the risk of patients developing an inappropriate dependency upon you, and be able to manage these situations appropriately – seeking advice from a colleague or professional body as necessary. | |
| D2.5.1.1 revealing intimate details about oneself. | D2.5.1.1 Sharing inappropriate intimate details about yourself. | Clarified wording. |
| D2.5.2 You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship | D2.5.2 You should avoid any behaviour which may be construed by a patient as inviting a sexual relationship or response. | Added 'or response' |
| D2.5.5 If you are sexually attracted to a patient, or if a patient displays sexualised behaviour towards you, you should seek advice from, for example, a colleague or professional body on the most appropriate course of action. If you believe that you cannot remain objective and professional, or that it is not possible to re-establish a professional relationship, you should refer your patient to another healthcare practitioner. If referring a patient because of your own sexual feelings towards them, you should endeavour to do so in a way that does not make the patient feel that | D2.5.5 If you are sexually attracted to a patient, or if a patient displays sexualised behaviour towards you, you should seek advice from, for example, a colleague or professional body on the most appropriate course of action. If you believe that you cannot remain objective and professional, or that it is not possible to re-establish a professional relationship, you should refer your patient to another healthcare practitioner. If you refer a patient because of your own sexual feelings towards them, you should endeavour to do so in a way that does not make the patient feel that they have done anything wrong. | Changed 'if referring' to 'if you refer'. |

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| they have done anything wrong. | | |
| D2.5.6 You must not take advantage of your professional standing to initiate a personal relationship with a patient. This applies even when they are no longer in your care, as any personal relationship may be influenced by the previous professional relationship which will have involved an imbalance of power between the parties. | D2.5.6 You must not take advantage of your professional standing to initiate a personal relationship with a patient. This applies even when the patient is no longer in your care, as any personal relationship may be influenced by the previous professional relationship, and an imbalance of power between the parties. | Changed 'they' to 'the patient', and modified final sentence to avoid either 'will' or 'may' regarding the imbalance of power. |
| D3.2: Where appropriate, you must also be open and honest with your colleagues and/or employers, and take part in reviews and investigations when requested. | 'You must also be open and honest with your colleagues and/or employers, where applicable, and take part in reviews and investigations when requested.' | Avoids ambiguity over use of 'where appropriate'. |
| D4 You must have a policy in place by which you manage patient complaints, and respond quickly and appropriately to any which arise. | D4 You must have a policy in place to manage patient complaints, and respond quickly and appropriately to any that arise. | Changed 'by which you' to 'to manage'. |
| D4.2 If you act constructively, allow patients the opportunity to express their dissatisfaction, and provide sensitive explanations of what has happened and why, you may prevent the complaint from escalating. | D4.2 In the event of a concern being raised, If you act constructively, allow patients the opportunity to express their dissatisfaction, and provide sensitive explanations of what has happened and why, you may resolve this at an early stage. | Specified 'in the event of a concern being raised'. Changed 'prevent complaint from escalating' to 'resolve any concerns at an early stage'. |
| D4.6 You should ensure that anyone making a complaint knows that they can refer it to the GOsC, and provide them | D4.6 You should ensure that anyone making a complaint knows that they can refer it to the GOsC, and provide them with appropriate details explaining | Added 'explaining the procedure'. |

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| with appropriate details. | the procedure. | |
| D5.2 Patients are entitled to obtain copies of their notes and you should assist them with this if such a request is made. | D5.2 Patients are entitled to obtain copies of their notes and you must comply with this if such a request is made in accordance with relevant legislation and good practice. | Tightened up the wording here to reflect that this is a 'must'. |
| D5.4 You should have a 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. Your patients should be made aware of this. | D5.4 You should have a written policy regarding retention, transfer and disposal of patient information and 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. Your patients should be made aware of this. | Added reference to a written policy and specified 'patient information and records'. |
| D5.6 You must comply with the law on data protection. For further information on data protection, please refer to the website of the UK Information Commissioner's Office. | D5.6 You must comply with the law on data protection and associated legislation. For further information on data protection, please refer to the website of the UK Information Commissioner's Office. | Added 'and associated legislation'. |
| D5.7 There may be times when you want to ask your patient…… | D5.7 There may be times when you want to ask a patient…… | Changed 'your' to 'a'. |
| D5.7.5 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? | D5.7.5 disclose only the information you need to, for example, does the recipient need to see the patient's entire medical history? | Deleted 'or their address, or other information which identifies them'. |
| D5. 8 In general, you should not disclose | D5.8 In general, you should not disclose confidential | Changed 'but' to 'however' and |

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| confidential information about your patient without their consent, but there may be circumstances in which you are obliged to do so; for example:<br>8.1 If you are compelled by order of the court, or other legal authority. You should only disclose the information you are required to under that order.<br>8.2 If it is necessary in the public interest. In this case, your duty to society overrides your duty to your patient. This will usually happen when a patient puts themselves or others at serious risk; for example, by the possibility of infection, or a violent or serious criminal act. | information about a patient without their consent, however there may be circumstances in which you are obliged to do so. Such circumstances might include:<br>8.1 If you are compelled by order of the court, or other legal authority. You should only disclose the information you are required to under that order.<br>8.2 If it is necessary in the public interest. In this case, your duty to society overrides your duty to your patient. This might happen when a patient puts themselves or others at serious risk; for example, by the possibility of infection, or a violent or serious criminal act. | 'will' to 'might'. |
| D5.12 If a patient is not informed before disclosure of confidential information takes place, you should record the reasons why it was not possible to do so, and maintain this with the patient's records. | D5.12 If a patient was not informed before disclosure of confidential information takes place, you should record the reasons why it was not possible to do so, and maintain this with the patient's records. | Changed 'is' to 'was'. |
| D6.2 It is illegal to refuse a service to someone on the grounds of their gender, ethnicity, disability, religion or belief, sexual orientation, transgender status, age, marital status or pregnancy. | D6.2 It is illegal to refuse a service to someone on the grounds of their age, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex or sexual orientation. | Added reference to marriage or civil partnership status to be consistent with A7, and put these in alphabetical order. |

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| D7<br>1.1 acting within the law at all times (criminal convictions could be evidence that an osteopath is unfit to practise)<br>1.2 not abusing alcohol or drugs<br>1.3 not behaving in an aggressive or violent way in your personal or professional life<br>1.4 showing compassion to patients<br>1.5 showing professional courtesy to those with whom you work<br>1.6 not allowing professional disputes to cause you to fall below the standards expected of you<br>1.7 not falsifying records, data or other documents<br>1.8 behaving honestly in your personal and professional dealings<br>1.9 maintaining the same standard of professional conduct in an online environment as would be expected elsewhere. | D7<br>1.1 acting within the law at all times (criminal convictions could be evidence that an osteopath is unfit to practise)<br>1.2 showing compassion to patients<br>1.3 showing professional courtesy to those with whom you work<br>1.4 behaving honestly in your personal and professional dealings<br>1.5 maintaining the same standard of professional conduct in an online environment as would be expected elsewhere<br>1.6 not abusing alcohol or drugs<br>1.7 not behaving in an aggressive or violent way in your personal or professional life<br>1.8 not allowing professional disputes to cause you to fall below the standards expected of you<br>1.9 not falsifying records, data or other documents | Retained the same content but reordered the paragraphs so that the 'dos' are first, before the 'nots'. |
| D8.5 You should declare to your patients any financial or other benefit you receive for introducing them to other professional | D8.5 You should declare to your patients any financial or other benefit you receive for introducing them to other professionals or commercial | Added an 's' to professional which slightly broadens the scope of this paragraph by |

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| or commercial organisations. You should not allow such an organisation to use your name for promotional purposes. | organisations. You should not allow such an organisation to use your name for promotional purposes. | including other professionals, rather than just organisations. |
| D9.2<br>1.1 patient confidentiality<br>1.2 retention of medical records<br>1.3 relationships with patients, colleagues and other healthcare professional<br>1.4 complaints<br>1.5 the work environment<br>1.6 health and safety<br>1.7 equality duties. | D9.2<br>1.1 Patient confidentiality.<br>1.2 Secure storage and retention of medical records.<br>1.3 Appropriate relationships with patients, colleagues and other healthcare professionals.<br>1.4 Complaints and associated procedures for handling them.<br>1.5 Maintaining a safe work environment.<br>1.6 Health and safety.<br>1.7 Duties under Equality legislation. | Some wording enhanced. |
| D10. You must consider the contributions of other health and care professionals to optimise patient care.<br>To achieve this, you should:<br>1. Treat other health and care professionals with respect, acknowledging the role that they may have in the care of your | D10 guidance:<br>1. To achieve this, you should:<br>1.1 Treat other health and care professionals with respect, acknowledging the role that they may have in the care of your patients. Any comments that you make about other healthcare professionals should be honest, valid and accurate. | Modified numbering of guidance paragraphs. |

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| patients. Any comments that you make about other healthcare professionals should be honest, valid and accurate.<br><br>2. Understand the contribution of osteopathy within the context of healthcare as a whole.<br><br>3. Follow appropriate referral procedures when referring a patient, or one has been referred to you.<br><br>4. Work collaboratively with other healthcare providers to optimise patient care, where such approaches are appropriate and available. | 1.2 Understand the contribution of osteopathy within the context of healthcare as a whole.<br><br>1.3 Follow appropriate referral procedures when referring a patient, or one has been referred to you.<br><br>1.4 Work collaboratively with other healthcare providers to optimise patient care, where such approaches are appropriate and available. | |
| D11 You must ensure that any problems with your own health do not affect your patients. You must not rely on your own assessment of the risk to patients. | D11 You must ensure that any issues with your own health do not affect your patients. You must not rely on your own assessment of the risk to patients. | Changed 'problems' to 'issues'. Seemed less judgemental. |
| D11.2 If you are exposed to a serious communicable disease, and you believe that you may be a carrier, you should stop practising until you have received appropriate medical advice, and follow any advice you are given about suspending or modifying your practice. You should take all necessary precautions to prevent | D11.2 If you are exposed to a serious communicable disease, and you believe that you may be a carrier, you should not practise until you have received appropriate medical advice, and follow any advice you are given about suspending or modifying your practice. You should take all necessary precautions to prevent transmission of the condition to patients. | Amended to replace 'stop practising' to 'not practise'. |

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| transmission of the condition to patients. | | |