General Osteopathic Council

Further Evidence of Practice form

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Introduction

1. All osteopaths practising in the United Kingdom must be registered with the General Osteopathic Council (GOsC). An applicant wishing to register must satisfy the GOsC that they meet the standards outlined in the GOsC *Osteopathic Practice Standards*. These standards can be accessed on the General Osteopathic Council (GOsC) website osteopathy.org.uk and at standards.osteopathy.org.uk. These set out the standards of conduct, ethics and competence required of osteopaths to promote patients' health and wellbeing, protect them from harm and maintain public confidence in the profession. They provide a framework to support the delivery of ethical, competent and safe osteopathic care.

2. This Further Evidence of Practice application is used as part of the assessment process to determine whether you meet the required standards. You should familiarise yourself with the *Osteopathic Practice Standards* prior to completing the questionnaire, as you will need to provide sufficiently detailed evidence to demonstrate your understanding and application of the standards.

3. The Further Evidence of Practice application comprises a number of questions relating to your practice and asks you to provide examples of specific aspects of practice where you have taken sole clinical responsibility. You will be asked to describe the case histories and clinical presentations, and submit anonymised copies of your clinic records. These examples should be as recent as possible and ideally within the last two years of practice.

4. As the applicant wishing to register, it is your responsibility to submit information which demonstrates that you are able to meet the standards of clinical safety, knowledge and skills required. If you are genuinely unable to provide patient records, you must inform the GOsC in advance as to why you cannot do so before you complete the application.

5. If the GOsC is satisfied with your reasons for not being able to produce patient records, then you will be requested to complete the application by providing written hypothetical scenarios for each of the questions, considering how you would manage the outlined circumstances. In doing so this allows you to demonstrate your clinical knowledge and thought processes, and your proposed clinical actions relevant to each circumstance.

6. When responding to the questions, it is important that you demonstrate your theoretical knowledge, your knowledge of testing procedures and how you use these to interpret findings in a clinical situation. (For example, if you are describing a case of a patient with upper extremity pain and paraesthesia, to state that the symptoms were in the C6 dermatome and that the C6 reflex was affected, does not provide sufficient detail to demonstrate that your clinical examination was supported by accurate knowledge of the relevant neuroanatomy, or that you applied diagnostic reasoning to the case. A description of where the symptoms were located in the upper extremity, which tendon reflexes, dermatomes and muscle groups were tested, what results were obtained and an explanation of their diagnostic significance is required.)

7. In addition to demonstrating your theoretical knowledge and skills and their application, the *Osteopathic Practice Standards* also place an emphasis on communication and patient partnership, safety and quality in practice and professionalism. This is why you are asked to describe how you involved the patient in gaining their consent; how you engaged them in shared decision-making throughout all phases of the consultation; and how you involved them in deciding upon the best course of treatment or management of their presenting complaint.

Assessment

8. Your evidence will be reviewed to determine whether you are able to proceed to the second stage of the assessment process, the Assessment of Clinical Performance (ACP).

9. Each question will be assessed on its own merits and then all responses will be considered together. This process of triangulation should allow for the strengthening of your claim to fulfil the *Osteopathic Practice Standards*.

10. If assessors of the Further Evidence of Practice recommend that the applicant progresses to the Assessment of Clinical Performance (ACP), then a summary of the outcomes of the Further Evidence of Practice will be provided to the ACP assessors.

Instructions for the completion of the form

- All application forms must be submitted in English.
- You should use the form below to type your response in the boxes provided. This should then be printed and returned with any further information which is requested.
- Please ensure that you include the reference number provided at the top of each page (if you do not have a reference number, then please contact the GOsC). Alternatively, if submitting via email, please use your reference number in the file name.
- Your name should not appear on any of the material you submit in your application.
- Some questions have suggested word counts – these are not mandatory but are given as a guide to the extent of the response required.
- Where questions ask for examples of real clinical cases, your answer must be accompanied by photocopies of the actual clinical records of the cases concerned. You must remove all references to the patients' names or other identifying features to preserve the anonymity of the patients.
- If your clinical records are not in English, or if they are in handwriting which may make them difficult to read, a certified translation in English must be provided.
- You must include a glossary of any abbreviations that you commonly use and any diagrams/charts should be clearly labelled. Failure to do this may delay your application.

Further Evidence of Practice form

Profile of your patients and caseload

Please use the table provided at the end of this document (Question 1 – Profile of patients and case load) to provide an overview of your osteopathic patients and case load for a three month period during your last year of practice.

The following should be considered:

- Gender
- Age
- Occupation
- Presenting complaint(s)

If you have any specialised areas of interest or focus, describe what they are and what approximate percentage of your patient load they represent.

Guidance

The GOsC is aiming to gain an insight of: the scope and breadth of your current clinical practice and patient profile; whether you have any areas of specialised focus; and your ability to collect and analyse data about your professional practice.

You should aim to provide information on 30-50 patient profiles. Please do not include any information which might identify the patient. You should submit anonymised copies of the case notes for each of the patients cited, and ensure that these copies are numbered to match the numbers in the patient profile table.

If you are not currently practising as an osteopath, please select a three-month period during the last year in which you were in osteopathic practice.

Ideally, you should only consider patients for whom you had sole responsibility for their management. If your working environment has been one where you have worked under the guidance of other healthcare professionals, then please describe these circumstances.

Relevant *Osteopathic Practice Standards*: B2, B4.

(Recommended word count: up to 250-300 words)

How do you keep your professional knowledge and skills up to date?

Discuss how you feel you have kept your professional knowledge and skills up to date over the last two years and what initiatives you have undertaken to monitor and enhance the quality of the osteopathic care you provide. With reference to your clinical practice outlined in response to question 1, pick two cases, and expand on how they helped you to enhance your professional and clinical skills.

Guidance

The GOsC is looking to gain an insight into how you personally keep your clinical and professional skills up to date and how this informs your osteopathic practice.

You should consider in your response:

- Your patient profile – choose two cases from the profile in your response to question 1 and discuss how they have contributed to enhancing your practice through professional development.
- Continuing professional development (CPD) activities – outline the professional development activities that you have undertaken over the last two years. These might include specific courses or activities that you have undertaken, as well as your general approach to CPD – for example, attending group meetings, doing case analyses with colleagues, undertaking a clinical audit, or receiving feedback on your practice from patients or colleagues.

Relevant Osteopathic Practice Standard(s): B3, B4.

Recommended word count: 500-1,000 words

Case presentations

In this section, you are asked to provide four separate case scenarios, which should be as recent as possible, ideally within the last two years. These should include one from categories 1-3 below, plus a case from either category 4 or 5. At least one of the cases should include a patient undergoing a course of treatment, rather than a single session:

Complete all of these:

1. A neuromusculoskeletal presentation

2. A musculoskeletal presentation with or without nerve involvement

3. A case where you concluded that the primary issue was non-musculoskeletal in origin, but mimics a musculoskeletal presentation.

Complete one of these:

4. A case where you referred the patient to another healthcare practitioner

5. A case where you felt that some osteopathic approaches/techniques were contraindicated from the outset, or had been indicated, but becomes no longer appropriate.

In each case, you should indicate how you involved the patient in making an informed decision about their management and treatment, and which *Osteopathic Practice Standards* you have demonstrated. Over the four cases, we are looking to see that you have demonstrated compliance with at least: Standards A1, A2, A3, A4, B1, B2, C1, C2, D10

An anonymised copy of the patient record in each case should be included with the completed form.

In each case, you should describe, where appropriate:

i. The case history including the patient profile, presenting complaint, and relevant medical, family and social history.

ii. Your assessment of the patient's general health.

iii. The contribution of any physiological, psychological, and social factors that you thought were relevant to the presenting complaint.

iv. Your examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system.

v. Your clinical findings, including any orthopaedic, neurological or systemic evaluation.

vi. Your interpretation of the significance of the presenting signs and symptoms

vii. Whether you adapted your approach and reflected on the outcomes.

viii. Your differential diagnostic hypothesis and the diagnostic conclusion you reached to explain the patient's presenting symptoms.

ix. How you applied osteopathic principles and concepts in the evaluation and treatment of the patient.

x. Whether the case was:

- Suitable for osteopathic treatment, and if so your treatment and management plan based upon your working diagnosis, the patient, and the likely effects and/or risks of osteopathic treatment. This should include an overview of the types of techniques used.
- Not suitable for osteopathic treatment and what steps you took to ensure ongoing care for the patient, whether this included referral to another healthcare practitioner and what the outcome was, if known. If referral was made, please include evidence (for example, an anonymised copy of the referral letter, annotation of a telephone conversation or copy email)

Case 1 (indicate which scenario the case outlines from numbers 1-5 above)
(Recommended word count: 1,500–2,000)
How you involved the patient in making an informed decision about their management and treatment
***Osteopathic Practice Standards* demonstrated:**

Case 2 (indicate which scenario the case outlines from numbers 1-5 above)
(Recommended word count: 1,500–2,000)
How you involved the patient in making an informed decision about their management and treatment
Osteopathic Practice Standards **demonstrated:**

Case 3 (indicate which scenario the case outlines from numbers 1-5 above)
(Recommended word count: 1,500–2,000)
How you involved the patient in making an informed decision about their management and treatment
Osteopathic Practice Standards **demonstrated:**

Case 4 (indicate which scenario the case outlines from numbers 1-5 above)
(Recommended word count: 1,500–2,000)
How you involved the patient in making an informed decision about their management and treatment
Osteopathic Practice Standards **demonstrated:**

Application of osteopathic techniques in practice

Please complete the table at the end of the document (Question 4 – Application of Osteopathic Techniques) to indicate in the appropriate box for each technique:

a) Your familiarity with each technique:
   Very familiar
   Partially familiar
   Unfamiliar with the technique

and

b) How frequently you use the technique in practice:
   Frequently
   Occasionally
   Never

c) For each technique which you use either frequently or occasionally, please state two situations in which the technique is unsuitable for use (contra-indications).

You should also give examples in the final column of the table of two cases (linked to the numbered cases within the patient profile table), of when you have used such techniques in practice.

Guidance

The GOsC wishes to gain an understanding of:

- The range of osteopathic techniques and approaches within your repertoire.
- Your understanding of the relative indications and contraindications of these.

Relevant *Osteopathic Practice Standards* B1, C1.

Question 1 - Profile of your patients and caseload table

Patient Number	Gender	Age	Occupation	Presenting complaint(s)

Question 4 – Application of osteopathic techniques in practice table

TECHNIQUES	FAMILIARITY			FREQUENCY OF USE			CONTRA-INDICATIONS	EXAMPLES OF WHEN USED MAPPED TO PATIENT PROFILE TABLE
	Very familiar	Partially familiar	Unfamiliar	Frequent	Occasional	Never		(indicate the case number in which techniques were employed – comments can also be added here if required)
Diagnostic Palpation								
Articulatory techniques/Articulation/ Mobilisation								
Muscle energy techniques/ Mitchell								
Osteopathic thrust techniques > High Velocity Thrust (HVT) > High Velocity, Low Amplitude (HVLA)								
Functional techniques								
Fascial techniques								
Involuntary mechanism techniques (cranial or cranio-sacral mechanism techniques)								
Soft tissue techniques								
Strain/counter strain techniques								
Visceral techniques								
Any other manual Techniques								