Further Evidence of Practice Questionnaire

Guidelines for Assessors

General Osteopathic Council

Contents

Introduction

1. These guidelines provide a reference for the evaluation of an applicant's questionnaire against the *Osteopathic Practice Standards*. They should be considered in conjunction with the underpinning checklist indicators provided in Appendix 1.

2. The 'decisions' required for each question enable the assessor to determine whether the applicant is able to provide sufficient evidence to fulfil the *Osteopathic Practice Standards* assessed by this questionnaire. In addition to considering whether the responses provided are sufficient, assessors should consider whether evidence is also plausible and credible. This process will involve completing Evaluation Form 1 (Appendix 2).

3. Having considered each question on its own merits, the assessor must then evaluate the combined responses against the *Osteopathic Practice Standards* by completing Evaluation Form 2 (Appendix 3) in a process of triangulation. This will lead to a decision as to whether the applicant is able to progress to the Assessment of Clinical Performance (ACP). There is also an obligation for the assessors to provide specific feedback to both the ACP assessors and the applicant.

4. The onus is on the applicant to provide sufficient evidence to support their claim to fulfil the *Osteopathic Practice Standards*. If, for genuine reasons, the applicant is unable to provide patient records, they will be asked to supply written evidence to support this claim before proceeding further with their application. If the GOsC are satisfied with the reasons provided, the applicant will then be asked to provide written hypothetical scenarios for each of the questions to demonstrate their knowledge, clinical reasoning skills and ensuing clinical actions. If the applicant does submit hypothetical scenarios then this should be clearly marked on the evaluation forms.

5. It is envisaged that each questionnaire will take approximately two hours to evaluate.

Questions

1 Profile of the applicant's patients and caseload

Evaluation guidance:

> The applicant should provide a breakdown of their patient profile and their presenting complaints for a three month period

> Is there evidence to suggest that the breadth or scope of the applicant's clinical practice is excessively narrow (for example: only treating children or specific conditions – sports injuries or back pain)?

> There should be consistency with the profile of the patients used in the questions in part 3

> The applicant should consider how these patient profiles have contributed to the maintenance and enhancement of their clinical competence and professional skills

> Have any areas of special interest or focus been identified?

> Has the applicant reflected upon areas requiring enhancement and how they intend to address this?

Decisions required:
Does the applicant provide evidence of?

B2 an adequate breadth/scope of patient profile to support their knowledge and skills as an osteopath

B4 self-reflection on their patient profile and how this informs the osteopathic management of their patients and future CPD initiatives

D3 their ability to collect and analyse data about professional practice

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

Evaluation guidance:

The applicant should consider in their response the following:

> Their patient profile

> Continuing professional development (CPD) activities

> Professional networking with colleagues

> Self-reflection on practice

> Feedback from colleagues and patients

> Case analysis and or clinical audit.

Decisions required:
Does the applicant provide evidence of?

B2 how their patient profile supports their knowledge and skills as an osteopath

B4 how their CPD activities maintain their knowledge and skills their ability to monitor, and act accordingly, on the quality of osteopathic care they provide

D3 their ability to collect and analyse data about professional practice

3 Neuromusculoskeletal case presentation

Evaluation guidance:

> There should be consistency between the case presentation and the anonymised copy of the patient records.

The applicant should consider the following in their response:

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

> Assessment of the patient's general health from the case history and the appearance and demeanour of the patient

> The contribution of any physiological, psychological, and social factors that they thought were relevant to the presenting complaint

> Their examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system. This should include observation of gait and posture, osteopathic examination of static and dynamic active and passive findings by observation and palpation in standing and/or sitting and recumbent positions

> How they assessed the patient's nervous system. This should be relevant to the case and is likely to include muscle power testing, deep tendon reflex testing and basic sensory testing

> Their clinical findings

> Their interpretation of the significance of the presenting signs and symptoms and whether this is plausible

> Their neurological differential diagnostic hypothesis and the diagnostic conclusion they reached to explain the patient's presenting symptoms

> How they concluded the case was suitable for osteopathic treatment, and/or required ongoing referral to a more appropriate healthcare professional

> What they told the patient about any material or significant risks associated with their proposed treatment or management plan

> How they involved the patient in making an informed decision about their own ongoing care

> The course of action that was followed.

Decisions required:
Does the applicant provide evidence of?

A3 any material or significant risks that they considered in the treatment and management of the patient

A5 how they involved the patient in any treatment and management planning and was the chosen course of action a reasonable one

A6 giving the patient sufficient information to enable them to make an informed choice about how they, the patient, wished to proceed.

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to osteopathic practice standard indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to osteopathic practice standard indicators under B2)

B3 their consideration of the need to seek advice or assistance for ongoing patient care.

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to osteopathic practice standard indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action in that they took into consideration the specific needs and expectations of the patient

C3 their attempting to understand the context of patient's presenting complaint and its significance to that patient

C7 their ability to provide appropriate care and treatment (reference checklist)

C8 the contents of the patient records being consistent with the requirements listed in osteopathic practice standard C8, allowing for the anonymity of the patient

D1 their consideration of the contribution of other healthcare professionals to ensure best patient care

4 Visceral (non-neuromusculoskeletal) case presentation

Evaluation guidance:

> There should be consistency between the case presentation and the anonymised copy of the patient records.

Consider whether the applicant has submitted and recorded, from both the case presentation and the case records, sufficient evidence regarding:

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

> Assessment of the patient's general health from the case history and the appearance and demeanour of the patient

> Their examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system. This should include observation of gait and posture, osteopathic examination of static and dynamic active and passive findings by observation and palpation in standing and/or sitting and recumbent positions

> How they assessed the relevant body system. This should be relevant to the case and informed by the case history

> Their interpretation of the significance of the presenting signs and symptoms and whether this is plausible

> Their differential diagnostic hypothesis and the diagnostic conclusion they reached to explain how they considered that the symptoms were in fact visceral (non-musculoskeletal) in origin

> How they concluded the case was suitable for osteopathic treatment, and/or required ongoing referral to a more appropriate healthcare professional

> What they told the patient about any material or significant risks associated with their proposed treatment or management plan

> How they involved the patient in making an informed decision about their own ongoing care.

Decisions required:
Does the applicant provide evidence of?

A3 any material or significant risks that they considered in the treatment and management of the patient

A5 how they involved the patient in any treatment and management planning and was the chosen course of action a reasonable one

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to osteopathic practice standard indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to osteopathic practice standard indicators under B2)

B3 consideration of the need to seek advice or assistance for ongoing patient care

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to osteopathic practice standard indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action in that they took into consideration the specific needs and expectations of the patient

C3 their attempting to understand the context of patient's presenting complaint and its significance to that patient

C7 their ability to provide appropriate care and treatment (please refer to osteopathic practice standard indicators under C7)

C8 the contents of the patient records being consistent with the requirements listed in osteopathic practice standard C8, allowing for the anonymity of the patient

D1 consideration of the contribution of other healthcare professionals to ensure best patient care

5 Referral of a patient to a healthcare professional

Evaluation guidance:

> There should be evidence of the referral method used – this should be clearly highlighted

> There should be consistency between the case presentation, the anonymised copy of the patient records and the information contained within the referral method used.

Consider from both the case presentation and the case records as to whether the applicant has submitted and recorded sufficient evidence regarding:

> The case history including the patient profile, presenting complaint, general health and relevant medical and social history

> The diagnostic hypothesis they reached to explain the patient's presenting symptoms

> How the case history data and the outcome of the clinical examinations informed their diagnostic hypothesis and whether this is a plausible conclusion

> Whether the case was suitable for osteopathic treatment

> Why they concluded that the case required referral to another healthcare professional and how they considered this would benefit the patient

> How they involved the patient in making this decision

> The mechanism of the referral with accompanying evidence. For example, an anonymised copy of the referral letter; case record annotation of a telephone conversation, a copy of an e-mail or any other documentation. Any written referral should contain a summary of the clinical features and the reason for the referral

> The outcome of the referral and any ensuing modification of their treatment and management plan and whether this is recorded on the patient records.

Decisions required:
Does the applicant provide evidence of?

A5 how they involved the patient in any treatment and management planning and was the chosen course of action a reasonable one

A6 giving the patient sufficient information to enable them to make an informed choice about how they, the patient, wished to proceed

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to checklist standard indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to the checklist indicators under B2)

B3 consideration of the need to seek advice or assistance for ongoing patient care

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to osteopathic practice standard indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action in that they took into consideration the specific needs and expectations of the patient

C3 their attempt to understand the context of the presenting complaint and its significance to the patient

C7 their ability to provide appropriate care and treatment (please refer to the checklist indicators under C7)

C8 the contents of the patient records being consistent with the requirements listed in osteopathic practice standard C8, allowing for the anonymity of the patient

D1 their consideration of the contribution of other healthcare professionals to ensure best patient care, which is also reflected in written communication or other clear mechanisms of patient referral

6 Case presentation in which the patient was considered unsuitable for osteopathic treatment.

Evaluation guidance:

> There should be consistency between the case presentation and the anonymised copy of the patient records.

Consider whether the applicant has submitted and recorded, from both the case presentation and the case records, sufficient evidence regarding:

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

> Their assessment of the patient's general health from the case history and the appearance and demeanour of the patient

> Their understanding of any physiological, psychological, and social factors that they thought was relevant to the presenting complaint and the feasibility of these

> Their examination and osteopathic assessment of the patient's biomechanic and musculoskeletal systems. This should include observation of gait and posture, osteopathic examination of static and dynamic active and passive findings by observation and palpation in standing and/or sitting and recumbent positions

> Their examination of the relevant body system, if applicable, and whether this was appropriate given the context of the presenting complaint

> Their interpretation of the significance of the presenting signs and symptoms and whether this is plausible

> The diagnostic hypothesis they reached to explain the patient's presenting symptoms

> How they arrived at the conclusion that this case was unsuitable for osteopathic treatment

> How they involved the patient in concluding that the presenting complaint was not suitable for osteopathic intervention

> The course of action they took to support the patient in finding a more appropriate healthcare professional to manage their presenting complaint and the mechanism of the referral undertaken.

Decisions required:
Does the applicant provide evidence of?

A3 any material or significant risks that they considered in the treatment and management of the patient

A5 how they involved the patient in any treatment and management planning and was the chosen course of action a reasonable one

A6 giving the patient sufficient information to enable them to make an informed choice about how they, the patient, wished to proceed

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to osteopathic practice standard indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to osteopathic practice standard indicators under B2)

B3 consideration of the need to seek advice or assistance for ongoing patient care

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to osteopathic practice standard indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action in that they took into consideration the specific needs and expectations of the patient

C3 their attempt to understand the context of the presenting complaint and its significance to the patient

C7 their ability to provide appropriate care and treatment (please refer to osteopathic practice standards indicators under C7)

C8 the contents of the patient records being consistent with the requirements listed in osteopathic practice standard C8, allowing for the anonymity of the patient

D1 consideration of the contribution of other healthcare professionals to ensure best patient care, which is also reflected in written communication or other clear mechanisms of patient referral

7 Two case presentations which demonstrate your osteopathic management of a patient

Evaluation guidance:

> There should be consistency between the respective case presentations and the anonymised copies of the patient records.

Consider whether the applicant has submitted and recorded, from both the case presentations and the patient records, sufficient evidence regarding:

> A complete and plausible case presentation that includes the case history, clinical examination and diagnostic rationale

> How they involved the patient in the proposed treatment and management planning

> Whether they informed the patient about any material or significant risks associated with the proposed treatment or management plan and how they were certain the patient understood

> Their knowledge of osteopathic principles and concepts

> How they apply their knowledge of osteopathic principles and concepts to the diagnostic processes/diagnostic thinking

> How they apply their knowledge of osteopathic principles and concepts to treatment and management planning

> Whether they re-assess the patient during a course of treatment and modify their treatment approach

> Reflection on the effectiveness on their clinical actions.

Decisions required

Does the applicant provide evidence of?

A3 any material or significant risks that they considered in the treatment and management of the patient

A5 how they involved the patient in any treatment and management planning and was the chosen course of action a reasonable one

A6 giving the patient sufficient information to enable them to make an informed choice about how they, the patient, wished to proceed

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to checklist indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to checklist indicators under B2)

B4 monitoring the quality of osteopathic care they provide by self-reflection

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to checklist indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action

C3 their attempt to understand the context of patient's presenting complaint and its significance to that patient

C7 their ability to provide appropriate care and treatment (please refer to checklist indicators under C7)

C8 the contents of the patient records being consistent with the requirements listed in osteopathic practice standard C8, allowing for the anonymity of the patient

8 Application of osteopathic techniques in practice

Evaluation guidance:

> Does the applicant declare being familiar with all of the following:
  > Diagnostic palpation
  > Articulatory techniques
  > Osteopathic Thrust Techniques
  > Soft tissue techniques

> Does the applicant declare frequent usage of all these above techniques (these are considered essential for osteopathic practice)?

> Does the applicant declare being partially familiar with two other categories of technique not included in the essential list above?

> Does the applicant demonstrate appropriate understanding and application of the declared techniques in use?

> Does the applicant demonstrate knowledge of at least two valid examples for contra-indications for each of the techniques in use?

> Is there consistency between the responses provided with those provided under questions 3, 4, 7 and 9 and/or the case examples provided in this question?

Decisions required
Does the applicant provide evidence of their ability to?

B2 apply osteopathic technique safely and effectively given the context of the presenting patient

C2 identify the suitability of, modification of, or contra-indication to using specific osteopathic techniques given the needs of the patient, the context of their presenting complaint and history.

9 Case presentation in which you concluded that certain techniques were unsuitable (contra-indicated)

Evaluation guidance

> There should be consistency between the case presentation and the anonymised copy of the patient records.

Consider whether the applicant has submitted and recorded, from both the case presentation and the case records, sufficient evidence regarding:

> The case history including the patient profile, presenting complaint, general health and relevant medical, family and social history

> The diagnostic hypothesis they reached to explain the patient's presenting symptoms and whether this was plausible

> The sufficiency of the case history data collected and the clinical examinations carried out to inform this diagnostic hypothesis

> Their osteopathic working diagnosis

> Their treatment and management plan based upon their consideration of the working diagnosis, the patient, and the likely effects of osteopathic treatment

> Why they decided that a particular technique was contra-indicated and if so was this was an appropriate decision

> The techniques they proceeded to use in the treatment given

> Why they chose these particular techniques, and any modifications they had to make to adapt to the needs of the patient, and if these choices and/or modifications were informed and appropriate

> What they informed the patient about any material or significant risks associated with the application of this (these) specific technique (s) and how they were certain they understood.

Decisions required

Does the applicant provide evidence of?

A3 any material or significant risks that they considered in the treatment and management of the patient

B1 their understanding of osteopathic concepts and principles, and how they apply them critically to patient care (please refer to checklist indicators under B1)

B2 sufficient knowledge and skills to support their work as an osteopath (please refer to checklist indicators under B2)

C1 their ability to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan (please refer to checklist indicators under C1)

C2 their ability to formulate a justifiable treatment plan or an alternative course of action

C3 their attempting to understand the context of patient's presenting complaint and its significance to that patient

C7 their ability to provide appropriate care and treatment (please refer to checklist indicators under C7)

C8 the contents of the patient records being consistent with the requirements listed in Osteopathic Practice Standard C8, allowing for the anonymity of the patient (please refer to checklist indicators under C8).

Appendix 1 Further Evidence of Practice Osteopathic Practice Standards Checklist

STANDARDS	CHECKLIST
A3 Give patients the information they need in a way that they can understand.	Does the applicant inform the patient: > About what to realistically expect from the applicant as an osteopath? > About any material or significant risks associated with any clinical action proposed pertinent to the specific patient's presenting situation and needs?
A5 Work in partnership with patients to find the best treatment for them.	Does the applicant: > Involve the patient in treatment and management planning? > Demonstrate a reasoned and appropriate course of management action for this specific patient?
A6 Support patients in caring for themselves to improve and maintain their own health.	Does the applicant: > Provide sufficient information for the patient to be able to make an informed choice as to which course of action they wish to proceed with? > Offer the patient the opportunity to inform their GP or other healthcare professionals about receiving osteopathic treatment?
B1 You must understand osteopathic concepts and principles, and apply them critically to patient care.	Does the applicant: > Apply osteopathic principles and concepts in their clinical decision making? > Justify and critique their understanding and application of osteopathic principles and concepts in evaluation and management specific to the patient? > Apply a range of osteopathic approaches that are informed by their analysis of the context of the presenting patient? > Consider the patient as whole in the context of the presenting complaint? > Use palpation as an evaluation, diagnostic, treatment and re-evaluation tool?
B2 You must have sufficient knowledge and skills to support your work as an osteopath.	Does the applicant demonstrate an underpinning knowledge base sufficient to: > Recognise the clinical signs of dysfunction and interpret their significance given the context of the specific patient and their presenting complaint? > Develop treatment and rehabilitation strategies given their understanding of the specific context of the patient? > Inform their clinical judgment and generation of diagnostic hypotheses throughout each phase of the consultation? > Recognise where there might be underlying pathology and facilitate the onward referral of the patient for additional or alternative investigations, and/or treatment? > Recognise any pertinent psychosocial issues and the impact these might have on the specific context of the presenting patient? > Apply osteopathic technique safely and effectively given the context of the presenting patient?

STANDARDS	CHECKLIST
B2 Continued. You must have sufficient knowledge and skills to support your work as an osteopath.	Does the applicant demonstrate: > The effective use of palpation as an evaluation tool? > How they interpret the findings of palpation to inform their clinical reasoning through the examination and treatment phases of the consultation? > The ability to carry out, and interpret, an evaluation of the patient that is informed by the presenting signs and symptoms, is modified to the needs of the patient, and includes observation, palpation and motion evaluation (both active and passive)? > Problem-solving and thinking skills, in their evaluation of the patient through the different phases of the consultation, that informs clinical reasoning and decision-making processes?
B3 Recognise and work within the limits of your training and competence.	Does the applicant: > Have the skills and competence to treat a patient? > Consider the need to seek advice or assistance for ongoing patient care?
B4 Keep your professional knowledge and skills up to date.	Does the applicant demonstrate: > That they have kept their professional knowledge and skills up to date? > That they are able to monitor, and act accordingly, on the quality of osteopathic care they provide? > How they integrate contemporary advice related to osteopathic healthcare into their practice? (for example: guidelines, risks and adverse reactions)
C1 You must be able to conduct an osteopathic patient evaluation sufficient to make a working diagnosis and formulate a treatment plan.	Does the applicant demonstrate the ability to: > Take and record a detailed case history? (This should include: any problems and symptoms reported by the patient; general health across all body systems; relevant medical, surgical and traumatic history; family and social history) > Make and record an analysis of the presenting complaint given the context of the case history? > Adapt their interview and enquiry skills to their perception of the specific needs of that patient? (for example: pain levels, psychosocial issues, and communication ability) > Take into consideration the significance of possible predisposing factors, such as physiological, psychological and social issues, in their analysis of the presenting complaint? > Select and conduct a range of clinical examinations / investigations that are initiated from the case history analysis and are adapted or modified to the needs of the patient? > Formulate diagnostic hypotheses informed by the analysis of the case history, observation of the patient, and the examination findings? > Develop a working osteopathic diagnosis?

STANDARDS	CHECKLIST
C2 You must be able to formulate and deliver a justifiable osteopathic treatment plan or an alternative course of action.	In developing a treatment and management plan does the applicant: > Select and justify a treatment and management approach that is developed from the information gathered from the different phases of the consultation, and informed by the working diagnosis? > Take into consideration the specific needs and expectations of the patient? > Consider their personal limits of competence? > Consider and discuss with the patient the likely effects of treatment? > Identify the suitability of, modification of, or contra-indication to using specific osteopathic techniques given the needs of the patient, the context of their presenting complaint and history? In applying treatment does the applicant > Monitor the effects of treatment during and after its application? > Adapt the application of either technique or treatment approach in response to ongoing palpation? > Evaluate post treatment response? > Justify the continuance, modification or cessation of osteopathic treatment? > Recognise, and take appropriate remedial action to deal with, an adverse reaction to osteopathic treatment?
C3 Care for your patients and do your best to understand their condition and improve their health.	Does the applicant demonstrate that: > They have attempted to understand the context of a patient's presenting complaint and its significance to that patient? > They have attempted to improve the patient's health and well-being?
C7 Provide appropriate care and treatment.	Does the applicant throughout each phase of the consultation, and overall, demonstrate that they are able to provide appropriate care and treatment for the patient?

STANDARDS	CHECKLIST
C8 Ensure that your patient records are full, accurate and completed promptly.	Do the patient records contain: > The date of the consultation? > The patient's personal details? > Any problems and symptoms reported by the patient? > Relevant medical, family and social history? > The clinical findings, including negative findings? > The information and advice provided, whether this is provided in person or via the telephone? > A working diagnosis and treatment plan? > Records of consent, including consent forms? > The investigation or treatment undertaken and the results? > Any communication with, about or from the patient? > Copies of any correspondence, reports, test results, etc. about the patient? > Clinical response to treatment and treatment outcomes? > The location of the treatment if outside the usual consulting rooms? > Whether a chaperone was present or not required? > Whether a student or observer was present?
D1 You must consider the contributions of other healthcare professionals to ensure best patient care.	Does the applicant: > Provide any evidence of consideration of other healthcare approaches in the management plan of the patient? > Understand the contribution of osteopathic treatment in context of primary care provision? > Consider referral to other disciplines in order to request further investigations as appropriate? > Understand the indications for referral? > Provide copies of communications with other healthcare professionals?
D3 You must be capable of retrieving, processing and analysing information as necessary.	Can the applicant provide evidence of: > Their ability to collect and analyse data about professional practice?

Appendix 2 Further Evidence of Practice Questionnaire Evaluation Form 1

To be completed with reference to the Further Evidence of Practice Questionnaire - Guidelines for assessors.

How the applicant's patient profile and CPD activities support the maintenance and development of their osteopathic capabilities.

1. Profile of the applicant's patients and caseload

B2

B4

D3

Other comments

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

B2

B4

D3

Other comments

3. Neuromusculoskeletal case presentation

A3

A5

A6

B1

B2

B3

C1

C2

C3

C7

C8

D1

Other comments

4. Visceral (non-neuromusculoskeletal) case presentation

A2

A5

B1

B2

B3

C1

C2

C3

C7

C8

D1

Other comments

5.Referral of a patient to a healthcare professional

A3

A5

A6

B1

B2

B3

C1

C2

C3

C7

C8

D1

Other comments

6. Case presentation in which the patient was considered unsuitable for osteopathic treatment.

A3

A5

A6

B1

B2

B3

C1

C2

C3

C7

C8

D1

Other comments

7. Two case presentations which demonstrate your osteopathic management of a patient

A3

A5

A6

B1

B2

B4

C1

C2

C3

C7

C8

Other comments

8. Application of osteopathic techniques in practice

B2

C2

Other comments

9. Case presentation in which you concluded that certain techniques were unsuitable (contra-indicated)

A3

B1

B2

C1

C2

C3

C7

C8

Other comments

Appendix 3 Further Evidence of Practice Questionnaire Evaluation Form 2

Now consider all the evidence submitted in this questionnaire to determine whether the applicant provides sufficient detail to satisfy the *Osteopathic Practice Standards* and to allow them to progress through to the Assessment of Clinical Performance (ACP). This sheet will be given to the ACP Assessors.

Please cross-refer between the individual questions and collate your feedback in the relevant sections below. You must consider areas where the osteopathic practice standards are met, areas requiring clarification and areas of omission.

	← Able to progress		Not able to progress →	
Osteopathic Practice Standards	**Evidence submitted to fulfil *Osteopathic Practice Standards***	**Majority of evidence submitted to support clinical safety and practice but areas requiring clarification**	**Some evidence submitted but major areas of clinical safety and practice omitted**	**Little or no evidence submitted.**
A: Communication and Patient Partnership A2,A3,A5,A6				
B: Knowledge, Skills and Performance B1-B4				
C: Safety and quality in practice C1-C3, C5-C8				
D: Professionalism D1, D3				

Recommendation: (please tick)

Progression through to the Assessment of Clinical Performance ☐	Not able to progress ☐
Evidence submitted to fulfil the Osteopathic Practice Standards	Some evidence submitted with major omissions of clinical safety and practice omitted
Majority of evidence submitted with areas requiring clarification	Limited or no evidence submitted.

For consideration by Assessment of Clinical Performance assessors:

Areas of good practice (please list and cross refer to the *Osteopathic Practice Standards*)

Areas requiring further exploration/clarification (please list and cross- refer to the *Osteopathic Practice Standards*)

Areas requiring enhancement

Appendix 4 Further Evidence of Practice Questionnaire

Reference number:

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*. This document is available on the GOsC website: www.osteopathy.org.uk.

2. This questionnaire 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 questionnaire 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 questionnaire.

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 questionnaire 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 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 questionnaire 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 it 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. A report from the evaluation of your questionnaire will be submitted to the assessors of the ACP to assist them in their assessment of your management of two new patients in a clinical setting. It will be conducted in English and held in the United Kingdom.

Instructions for the completion of the form

> All questionnaires **must** be submitted in English.

> You should use the form below to type your response in the boxes provided. The form 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 questionnaire.

> 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 labeled. Failure to do this may delay your application.

Further Evidence of Practice Questionnaire

1. 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)

Reflecting upon the information you have provided in the table briefly discuss how you consider that these patients, and their presenting complaints, have helped you to maintain your clinical and professional skills.

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

Please also consider any areas of your practice that you would like to strengthen and how you might achieve this.

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.

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. D3.

(*Recommended word count: 250 - 300 words*)

2. 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 and what initiatives you have undertaken to enhance and monitor the quality of osteopathic care you provide.

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 a number of areas:

> Your patient profile
> Continuing professional development activities
> Professional networking with colleagues
> Self-reflection on practice
> Feedback from colleagues and patients
> Case analysis and/or clinical audit.

Relevant Osteopathic Practice Standard(s):
B2, B4. D3.

(*Recommended word count: 500 - 1000 words*)

3. Neuromusculoskeletal case presentation

Describe a past case in which a patient presented with real or apparent neurological symptoms; the steps you took in managing this case; how you involved this patient in your decision-making and helped them make an informed choice as to their ongoing care.

The case should be one in which you suspected or found neurological involvement as a result of musculoskeletal dysfunction.

Guidance:

Please describe in your case presentation:

- The case history including the patient profile, presenting complaint, and relevant medical, family and social history
- Your assessment of the patient's general health
- The contribution of any physiological, psychological, and social factors that you thought were relevant to the presenting complaint
- Your examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system
- Your assessment of the patient's nervous system
- Your clinical findings
- Your interpretation of the significance of the presenting signs and symptoms
- Your neurological differential diagnostic hypothesis and the diagnostic conclusion you reached to explain the patient's presenting symptoms
- 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
  - Not suitable for osteopathic treatment and what steps you took to ensure ongoing care for the patient and whether this included referral to a more appropriate authority and what the outcome was, if known.
- How you involved the patient in making an informed decision about their ongoing care.

Relevant Osteopathic Practice Standards

A3, A5, A6. B1, B2, B3. C1, C2, C3, C7, C8. D1.

(*Recommended word count: 1500 – 2000)*
Please attach an anonymised copy of your complete patient record.

4. Visceral (non-neuromusculoskeletal) case presentation

Describe a recent past case in which a patient presented with apparent musculoskeletal symptoms, which in fact you concluded were visceral (non-musculoskeletal) in origin. Discuss how you managed this situation; how you involved this patient in your decision-making, and helped them make an informed choice as to their ongoing care.

Guidance:

Please describe in your case presentation:

- The case history including the patient profile, presenting complaint, and relevant medical, family and social history
- Your assessment of the patient's general health
- Your examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system
- Your examination of the relevant body system(s)
- Your clinical findings
- Your interpretation of the significance of the presenting signs and symptoms
- Your differential diagnostic hypothesis and how you finally concluded that the symptoms were in fact visceral (non-musculoskeletal) in origin
- 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
  - Not suitable for osteopathic treatment and what steps you took to ensure ongoing care for the patient, and the outcome if known.
- How you involved the patient in making an informed decision about their ongoing care.

Relevant Osteopathic Practice Standards
A3, A5. B1, B2, B3. C1, C2, C3, C7, C8. D1.

(*Recommended word count: 1500 – 2000)*
Please attach an anonymised copy of your complete patient record.

5. Referral of a patient to a healthcare professional

Describe your most recent case in which, after clinical evaluation, you concluded that the patient should be referred to another healthcare professional.

Guidance:
The purpose of this question is to determine how you came to the conclusion that the patient required referral to another healthcare professional; the contribution you felt that they would make to the well-being of the patient; how you involved the patient in reaching this decision and gained their consent to make the referral; the mechanism of the referral; the outcome, if known, and how this informed your ongoing care of the patient.

In answering this question, please consider the following:

> The case history including the patient profile, presenting complaint, general health and relevant medical, family and social history
> The diagnostic hypothesis you reached to explain the patient's presenting symptoms
> How the case history data and the outcome of your clinical examinations informed this diagnostic hypothesis
> Whether the case was suitable for osteopathic treatment
> Why you concluded that the case required referral to another healthcare professional and how this would benefit the patient and your role in their ongoing care
> How you involved the patient in making this decision
> The mechanism of the referral with accompanying evidence. For example: an anonymised copy of the referral letter; case record annotation of a telephone conversation, a copy of an e-mail or any other documentation
> The outcome of the referral and any ensuing modification of your treatment and management plan.

Relevant Osteopathic Practice Standards
A5, A6. B1, B2, B3. C1, C2, C3, C7, C8. D1.

(*Recommended word count: 1500 – 2000)*
Please attach an anonymised copy of your complete patient record for this case highlighting the mechanism of referral clearly within the patient records (this should include any correspondence).

6. Case presentation in which the patient was considered unsuitable for osteopathic treatment.

Describe your most recent case in which, after clinical evaluation, you concluded that the patient was unsuitable for osteopathic treatment.

Guidance:
This question provides an opportunity for you to discuss how you work with and support a patient to find the best treatment option for them. Your response should also give an insight into how you use your professional judgment to assess whether you have the training, skills and competence to treat a patient.

The following should be considered in your response:

> The case history including the patient profile, presenting complaint, and relevant medical, family and social history
> Your assessment of the patient's general health
> The contribution of any physiological, psychological, and social factors that you thought were relevant to the presenting complaint
> Your examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system, and relevant body system(s)
> Your clinical findings
> Your interpretation of the significance of the presenting signs and symptoms
> The diagnostic hypothesis you reached to explain the patient's presenting symptoms
> How you arrived at the conclusion that this case was unsuitable for osteopathic treatment
> How you involved the patient in concluding that the presenting complaint was not suitable for osteopathic treatment
> The course of action you took to support the patient in finding a more appropriate healthcare professional to manage their presenting complaint, and the mechanism you used to refer them, which should be included in your case records.

Relevant Osteopathic Practice Standards
A3, A5, A6. B1, B2, B3. C1, C2, C3, C7, C8. D1.

(*Recommended word count: 1500 – 2000)*
Please attach an anonymised copy of your complete clinical records for this case.

7. Two case presentations which demonstrate your osteopathic management of a patient

Describe two past cases which demonstrate your understanding and interpretation of osteopathic principles and concepts, and how these informed and guided your shared decision making with the patient in any treatment given, and any shared rehabilitation and management strategies.

Guidance:
The GOsC requires you to provide evidence that you have sufficient knowledge and skills to support your work as an osteopath and how you apply osteopathic principles and concepts in all phases of the treatment encounter. This question also expects you to discuss how you worked with and supported these patients in finding the best course of care and treatment for them; and how you use your patient profile to reflect on your osteopathic practice.

For each case, describe:

> The case history including the patient profile, presenting complaint, general health, and relevant medical, family and social history
> Your examination and osteopathic assessment of the patient's biomechanics and musculoskeletal system, and any examination of relevant body system(s)
> Your clinical findings
> Your interpretation of the significance of the presenting signs and symptoms
> The diagnostic hypothesis you reached to explain the patient's presenting symptoms
> Your osteopathic working diagnosis
> Your treatment and management plan based upon your working diagnosis, the patient, and the likely effects of osteopathic treatment
> What you told the patient about any material or significant risks associated with your proposed treatment or management plan and how you were certain they understood
> Discuss how you applied osteopathic principles and concepts in the evaluation and treatment of the patient
> Your choice of treatment approach together with why you thought this was a suitable option
> Whether you changed your treatment approach through the course of treatment and your reasons why
> How you reflected on the effectiveness of the treatment and management strategies you employed, and whether in hindsight you would have changed or modified them in any way.

Relevant Osteopathic Practice Standards
A3, A5, A6. B1, B2, B4. C1, C2, C3, C7, C8.

(*Recommended word count: 1500 – 2000 for each case*)
Please attach an anonymised copies of your complete clinical records for the two cases.

8. Application of osteopathic techniques in practice

Please complete the table at the end of the document (Question 8 – 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) and clearly cross-reference these to examples in the clinical records for questions 3, 4, 5, 6 and 7.

Please discuss the reasons why you chose the techniques used in these cases, with reference to the patient profile and presenting complaint.

If the copies of your clinical records do not demonstrate your use of a particular technique, please provide a short clinical example of your use of the technique to demonstrate your understanding and application (200 – 400 words). **Please attach anonymised copies of the clinical records for these cases**.

Guidance:
The GOsC wishes to gain an understanding of: whether you have an appropriate range of osteopathic techniques within your repertoire; whether you have sufficient knowledge and skills to choose a technique(s) that is based upon your analysis of the working diagnosis, the patient, your own limits of competence; the likely effect of the chosen technique.

The question is also looking to gain an understanding as to your ability to identify indications and contra-indications to the use of osteopathic technique.

Relevant Osteopathic Practice Standards
B2. C2.

9. Case presentation in which you concluded that certain techniques were unsuitable (contra-indicated).

Describe your most recent case in which you concluded, after clinical evaluation, that although the patient was suitable for osteopathic treatment a certain technique or techniques should be avoided or were contra-indicated.

Guidance:
This question is looking to gain an understanding of your ability to identify indications and contra-indications to the use of osteopathic techniques. It is also looking to understand how and when you might modify the application of a specific technique as a result.

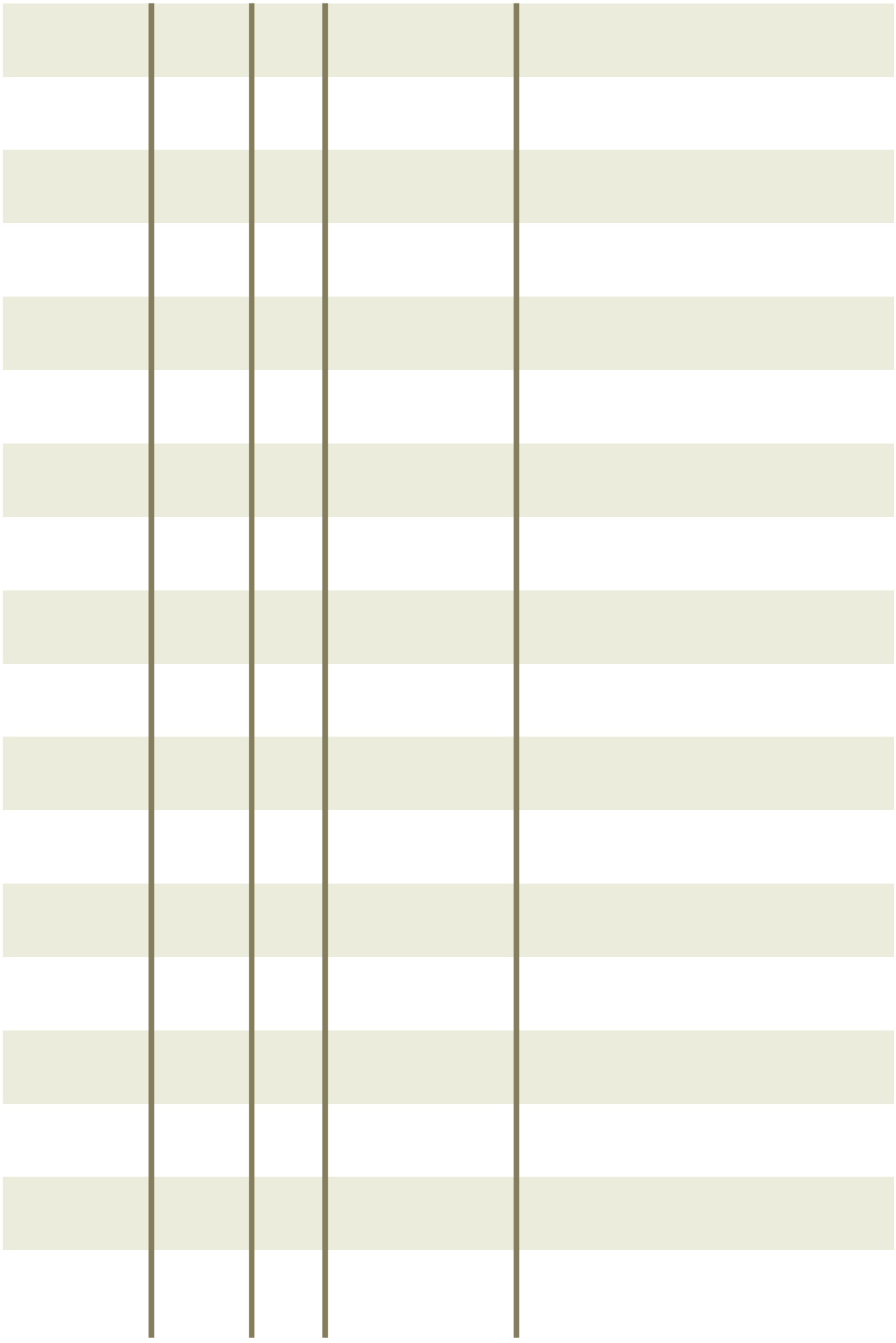
Please describe:
> The case history including the patient profile, presenting complaint, general health and relevant medical, family and social history
> The diagnostic hypothesis you reached to explain the patient's presenting symptoms
> How the case history data and the outcome of your clinical examinations informed this diagnostic hypothesis
> Your osteopathic working diagnosis
> Your treatment and management plan based upon your working diagnosis, the patient, and the likely effects of osteopathic treatment
> Why you decided that a particular technique was contra-indicated
> The techniques you proceeded to use in the treatment given
> Why you chose these techniques, and any modifications you had to make to adapt to the needs of the patient.
> What you told the patient about any material or significant risks associated with the application of this/these specific technique(s) and how you were certain they understood.

Relevant Osteopathic Practice Standards
A3. B1, B2. C1, C2, C3, C7, C8.

(*Recommended word count: 1500 – 2000)*
Please attach an anonymised copy of your complete clinical records for this case.

Question 1 - Profile of your patients and caseload

Patient	Gender	Age	Occupation	Presenting complaint(s)



Question 8 – Application of osteopathic techniques in practice

TECHNIQUES	FAMILIARITY			FREQUENCY OF USE			Contra-indications and cross-referencing
	Very familiar	Partially familiar	Unfamiliar	Frequent	Occasional	Never	
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							