



Appendix 1:  
A Review of Literature  
on the Osteopathic  
Profession, Osteopathic  
Practice and Osteopathic  
Regulation in the UK

Report to the General  
Osteopathic Council  
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# **Appendix 1: A Review of Literature on the Osteopathic Profession, Osteopathic Practice and Osteopathic Regulation in the UK**

## **Introduction**

This review provides background and context as to the nature and practice of osteopathy and its regulation as a profession in the United Kingdom (UK). In order to provide an insight into the foundations of modern osteopathy this review begins with a brief review of the historical developments of osteopathy, from its conception in the USA to its establishment as a regulated healthcare profession in the UK. Table 5 illustrates the key policy documents which have helped shape the profession in its current form, and is provided at the end of this review. A timeline of historically significant events that have served to shape the form of osteopathy in the UK is presented in Table 3. The second part of this review begins by examining the nature of osteopathic clinical practice including different definitions of osteopathy, its process of professionalisation in the UK and evidence based-practice in relation to osteopathy.

### **1.1 The early development of osteopathy in the UK**

The beginnings of osteopathy may be traced back to the USA, during the latter half of the 19<sup>th</sup> century, when an American frontier physician, Andrew Taylor Still, founded osteopathy in response to what he felt was a severely inadequate and often harmful system of medical care (Seffinger et al., 2010). Still amalgamated his interests in traditional bone-setting (Pettman, 2007)<sup>1</sup>, magnetic healing, anatomy and physiology (Peterson, 2003) and developed a 'new' drugless, non-surgical approach to healthcare, he termed osteopathy. Throughout the late 19<sup>th</sup> and early 20<sup>th</sup> century, osteopathy grew in the USA, and at the start of the 1900s, a small number of American trained osteopaths began practicing in the UK, and when numbers grew sufficiently, the British Osteopathic Society (BOS) was formed in 1903 (Collins, 2005).

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<sup>1</sup> *Bonesetters* were some of the earliest practitioners of spinal manipulation before the advent of osteopathy, chiropractic and physiotherapy. While spinal manipulation can be traced back to Hippocrates (460–385 BCE), the craft of bone-setting became popular throughout Europe and Asia in the 16<sup>th</sup> century as a natural healing therapy (Pettman 2007).

Throughout the first ten years of the 20<sup>th</sup> century, many of the osteopaths in the UK were self-taught or had served as apprentices to American-trained osteopaths (Baer, 1988). Wanting to fulfil the need of formally trained osteopaths in the UK, an American-trained British osteopath, John Martin Littlejohn opened the first UK osteopathy education institution, on the 7<sup>th</sup> March, 1917, the British School of Osteopathy (BSO), London.

## **1.2 Drive towards recognition, regulation, and registration**

By 1910, with a small number of osteopaths, many with questionable standards of training, twelve osteopaths convened in Manchester to establish the British Osteopathic Association (BOA) (Baer, 1988; Collins, 2005). The BOA was recognised by the American Osteopathic Association (AOA), and according to Collins (Collins, 2005) its key purpose was to uphold professional standards and provide the public with a record of suitably qualified osteopaths. Almost a decade later, the BOA set up the ‘Osteopathic Defence League’, with an American trained osteopath, William Streeter as the Honorary Secretary (Collins, 2005). The roles of this league were to alter the law, and put osteopathy on the same platform of legal equality as the orthodox medical profession, and to make the principles of osteopathy more widely known (Collins, 2005).

The League gained strong support from within and outside of osteopathy. One key supporter was Arthur Greenwood MP, who had held the position of Parliamentary Secretary for the Minister of Health in 1924. With his influence, and the growing support for osteopathy, a debate in the House of Commons proceeded regarding the introduction of legislation to ensure the recognition and legal registration of osteopathy (Collins, 2005). However, after considerable debate in the Commons, with Littlejohn as spokesman of the BOA, the then Minister of Health, Neville Chamberlain insisted that:

“If they want to have a register of osteopaths set up in this country,  
the first thing for them to do is to start colleges of their own”

(cited in Collins, 2005, p.54)

Chamberlain felt that the osteopathic curricula had to approach the standards of education and professionalism throughout the rest of the UK (Collins, 2005).

In 1930, still in pursuit for legal recognition, the BOA sought to obtain a Royal Charter to incorporate it as a legal entity, in the hope that the legal protection of the title 'Osteopath' would follow. After a lengthy effort, the application for a Royal Charter was refused (Walker and Budd, 2002), though the process itself had stirred up an interest in osteopathy, and sparked debates between osteopaths and the medical profession (Collins 2005). Bills to establish a government-sanctioned register for osteopaths were submitted to the House of Commons in 1931, 1933 and 1934, all of which were unsuccessful (Baer, 1988). It is interesting to note that in the unsuccessful Bill of 1934, the BOA sought to acquire similar rights as medical practitioners (for example, to perform minor surgeries and to certify deaths), but the Health Minister at the time found the Bill and these requests unacceptable (Walker and Budd, 2002).

In 1935, the Select Committee of the House of Lords met again to consider a Bill for the registration and regulation of osteopaths (Walker and Budd, 2002). The Bill, which had support from the BOA, the BSO, the Osteopathic Defence League, and the Incorporated Association of Osteopaths (IAO) strongly asserted that "an unqualified and incompetent quack and complete charlatan would be disbarred from practicing osteopathy" (cited in Baer, 1988, p.19). The parties met intensely over a period of twelve days, but the Bill yet again failed. The opposition, internal struggles, the inability to readily define osteopathy, only one educational institution (the BSO) which offered a substandard curriculum and a very large number of unqualified practitioners in operation have been cited as reasons for the failure of the 1935 Bill (Baer, 1988).

The findings of the Select Committee led to a recommendation that the osteopathic bodies concerned (BOA, BSO, ODL, IAO) set up a voluntary register and reputable educational system (Walker and Budd, 2002). Upon this recommendation, the three main bodies in the UK; the British Osteopathic Association, Incorporated Association of Osteopaths and the National Society of Osteopaths united together to form the General Council and Register of Osteopaths (GCRO) (Baer, 1988). In 1936, the GCRO was incorporated as a company, whose main functions were to 1) regulate the standard of qualification and professional conduct; 2) protect the public by providing them with details of competently trained osteopaths (Collins, 2005). The GCRO offered different levels of membership to respond to the varying levels of training osteopaths had at the time. Full membership was granted to graduates of

American colleges, and once appropriate changes were made to the curriculum, BSO graduates were permitted full membership (Baer, 1988). Associate members included those lacking specific academic qualifications, but had been practicing for a reasonable amount of time, and if desired could upgrade to full membership status by satisfying the examination board (Collins, 2005).

Throughout the following four decades, membership of the GCRO steadily grew, and in 1986 a charity called the Osteopathic Genesis Foundation commissioned the first major research project to provide a detailed picture of how osteopathy was developing as a profession. Conducted by the private research firm, Medicare Research Ltd (1987), the findings provided previously unknown detailed information on many different aspects of the profession including the size of osteopathic practices, location, scale of fees, attitudes towards the promotion of the profession and also the nature of presenting patients (for example, location and nature of symptoms, the diagnosis and osteopaths' approach to treatment) (Medicare Research Ltd, 1987).

By 1989 there were 1308 members registered with the GCRO (Collins, 2005). Up until this time, professional regulation and compulsory registration had been continually discussed, and in 1989 a Working Party was established by The King's Fund<sup>2</sup> to consider the scope and content of legislation to regulate osteopathy (Walker and Budd, 2002). The report produced by the Working Party on Osteopathy set out clear recommendations for the regulation of osteopathy (King's Fund, 1991). Legislation documents contained a draft 'Osteopaths Bill', and a framework for the establishment of the General Osteopathic Council (GOsC), which would have the statutory duty to develop, promote and regulate the osteopathic profession (Collins, 2005). Existing osteopaths wanting to apply for registration had a period of two years (between 1998-2000), to submit an application (Walker and Budd, 2002). Applicants had to compile a comprehensive application, in the form of a Professional Profile and Portfolio (PPP) (Collins, 2005). After this 'transition period', only those osteopaths who were in possession of a Recognised Qualification (RQ) from an osteopathic education institution recognised by the GOsC would be eligible for registration. There are also provisions within the Osteopaths Act to enable recognition of international qualifications - international and EU routes to registration. A further 'new powers' route opened up a further window of

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<sup>2</sup> *The King's Fund* is an independent charitable organisation that works to improve health care in the UK by providing research and health policy analysis and publications (The King's Fund 2012).

opportunity for those with UK s to be registered but this closed in 2009. Failure to register, with either of these routes during the transition period, would mean it would be an offence, and illegal to use the title of 'Osteopath'.

Hearings of the Osteopaths Bill occurred for almost two years in both the House of Commons and House of Lords, following which the Osteopaths Act 1993 was given Royal Assent on the 1<sup>st</sup> July 1993, with the act coming into effect in May 2000 (Walker and Budd, 2002). It is worth noting, that prior to the passing of the Osteopaths Act in 1993, no other complementary therapy discipline (we note debate about whether osteopathy is a complementary therapy) had achieved statutory regulation, although the Chiropractors Act (1994) was passed the following year. According to the Osteopaths Act (1993), The GOsC is required to; 1) Determine the Standard of Proficiency required for the competent and safe practice of osteopathy and publish a statement of that standard; 2) Publish a Code of Practice laying down the standards of conduct and practice expected of a registered osteopath and give guidance in relation to the practice of osteopathy.

Part of The King's Fund report in 1991 highlighted that continued registration should be conditional on practitioners' continued osteopathic education (King's Fund, 1991). However, it wasn't until 2007 (following a pilot scheme in May 2004) that the GOsC introduced mandatory Continuing Professional Development (CPD), and osteopaths must complete thirty hours of CPD every year, of which fifteen hours must involve learning with others. A GOsC discussion document<sup>3</sup>, published in 2011, provided information about the CPD scheme and outlined GOsC's thinking at the time about how it might be improved. While many CPD courses provide additional training in areas of osteopathic practice, such as further manual therapy treatment techniques, practitioners may also attend courses that fall outside the traditional spectrum of osteopathic training such as medical imaging, exercise rehabilitation and acupuncture, and may contribute to a cross pollination of knowledge and skills between different healthcare professions. Many of these short CPD courses are advertised to practitioners throughout the national osteopathic press (for example, The Osteopath Magazine, 2013).

### **1.3. Modern developments in osteopathic regulation and education (post-1995)**

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<sup>3</sup> [http://www.osteopathy.org.uk/uploads/cpd\\_discussion\\_document\\_public.pdf](http://www.osteopathy.org.uk/uploads/cpd_discussion_document_public.pdf)

By 1997 the GOsC was formally operational, and the first Registrar and Chief Executive, Madeleine Craggs appointed Derrick Edwards (formally Vice-Principal of the BSO) as the Director of Education. The Education Department of the GOsC commenced drafting documents for the process leading to Recognised Qualification status, and thirteen osteopathic institutions showed an interest in being recognised providers of osteopathic education.

In the UK, there are currently eleven osteopathic education institutions (OEs) providing undergraduate training (lasting four years full-time or five years part-time) and post-graduate osteopathic training, which is recognised and quality assured by the GOsC every three to five years (note: The College of Osteopaths operates in two locations; Hertfordshire and Staffordshire). These include OEs within wider universities and independent OEs, solely providing osteopathic training validated by British universities. The London College of Osteopathic Medicine offers postgraduate training in osteopathy exclusively to medical doctors. Osteopaths graduating from these recognised courses are entitled to practise independently, using the protected title ‘osteopath’ (General Osteopathic Council, 2012d). Training courses currently recognised by the GOsC are shown in Table 1.

<b>Osteopathic education institution (OEI)</b>	<b>Location</b>
British College of Osteopathic Medicine (validated by Plymouth University)	London
British School of Osteopathy (validated by University of Bedfordshire)	London
The College of Osteopaths (validated by Middlesex University)	Hertfordshire
The College of Osteopaths (validated by Staffordshire University)	Staffordshire
The European School of Osteopathy (validated by University of Greenwich)	Kent
Leeds Metropolitan University	Leeds
London College of Osteopathic Medicine (qualified medical doctors only)	London
London School of Osteopathy (validated by the University of East Anglia)	London

Oxford Brookes University (course due to terminate by 2015)	Oxford
The Surrey Institute of Osteopathic Medicine (validated by University of Surrey)	Surrey
Swansea University	Swansea

Table 1: Osteopathy training courses recognised by the General Osteopathic Council (General Osteopathic Council, 2012d)

Different UK OEIs place emphasis on different aspects of osteopathy, osteopathic techniques and clinical approaches, stemming from diversities in their historical development, which contributes to a diverse professional osteopathic landscape. For example, the British College of Osteopathic Medicine (BCOM) was founded in 1936 by an eminent Osteopath and Naturopath<sup>4</sup>, Stanley Lief (British College of Osteopathic Medicine, 2013a), and as such osteopathic education at BCOM has incorporated many aspects of naturopathy such as nutritional advice and hydrotherapy (British College of Osteopathic Medicine, 2013c). The European School of Osteopathy (ESO) was founded in Paris in 1951 (European School of Osteopathy, 2013). Owing to the popularity of cranial and visceral approaches to osteopathy in France and continental Europe, these aspects of practice have been and continue to be strong features in the osteopathic education at the ESO (European School of Osteopathy, 2013). Osteopathic education has undergone considerable change since the first Diploma of Osteopathy was awarded in the UK in 1925 (Collins 2005). This evolution of the osteopathic qualification awarded by OEIs is shown in Table 2, and represents the development and progression of osteopathic education provision in the UK.

**1925-** First Diploma in Osteopathy awarded (DO)

**1992-** First Bachelor of Science in Osteopathy awarded (BSc)

**2006-** First Master of Osteopathy awarded (MOst)

Table 2: Development of osteopathic qualifications offered by OEIs

<sup>4</sup> *Naturopathy* is a form a natural medicine which uses natural treatment modalities (such as massage, hydrotherapy and dietetics) to encourage the innate healing capacity of the body (British College of Osteopathic Medicine, 2013c)



As noted above, upon graduating from recognised OEs, osteopaths are entitled to practise independently and there have been concerns about new osteopaths' ability to do so. A report by Prof Della Freeth and colleagues (2012) on 'New Graduates' Preparedness to Practice' examined the perceptions of this issue among osteopaths recently registered with the GOSc, osteopaths in their final year of study, more experienced osteopaths and staff at OEs.

The report noted that new osteopaths usually emerged from OEs competent in clinical practice, with up-to-date knowledge, adequate clinical skills, awareness of Osteopathic Practice Standards and a generally positive attitude towards evidence-based practice (although also noting a lack of availability of evidence, both because the osteopathic evidence was not well developed and because their access to academic journals was limited after graduating). However, they master osteopathic practice more through experience, working as an osteopath in practice, than through training. New osteopaths were often described as 'safe, if not always effective', with sufficiently incisive clinical reasoning skills or ability to develop patient management plans, sometimes choosing inappropriate investigations or interventions, being overly cautious or over-treating patients.

The report also raised concerns about new osteopaths' communication skills. While new osteopaths were seen to be able to explain treatments to patients, they were less able to deal with more complex communications with patients who were anxious, frustrated or in pain. They also often struggled to communicate effectively with other health care professions. OEI training in communication and interpersonal skills appeared somewhat 'patchy' and ad hoc; students commonly appeared to learn communication skills from tutors through a process of 'osmosis' but their experience in this regard was mixed, some positive, some negative. Again, effective communication skills were therefore commonly learned through experience in practice.

The report noted that new osteopaths lack training in the skills needed to build an osteopathy business and there was little consensus and diverse views about the nature of osteopathic professionalism, although broad agreement that it generally involved self-monitoring of strengths and weaknesses throughout osteopaths' careers. This ambiguity and diversity in relation to professionalism raises the potential problem of new osteopaths struggling to deal with professional and ethical dilemmas in their practice.

These issues, relating to safe but suboptimal practice, limited interpersonal and communication skills, and ambiguity around professionalism, were of particular concern due to the autonomous and independent nature of osteopathy, which was fundamental to osteopaths' professional identities. As the report noted, most osteopaths work on a self-employed basis, many work independently and in isolation from professional colleagues. There appears to be with a lack of well-developed mentoring processes to support new osteopaths in the early stages of their careers. The report warned that OEI's emphasis on developing new osteopaths with safe clinical practice should not distract attention from the importance of developing high quality interpersonal and communication.

Consequently CPD and support for new graduates, both in terms of access to sources of osteopathic evidence and more experienced osteopathic colleagues, were seen to be important. Accordingly, these issues could, in part, be addressed through processes relating to demonstrating continuing fitness to practise, which we will shortly discuss.

### 1.3.1. Development and implementation of Standards of Practice

With a desire to ensure that the standard of osteopathic education was consistent amongst the OEIs, in 1998 the GOsC produced a document (based on the King's Fund report of 1991) which outlined the first iteration of the 'Standards of Proficiency' (Table 5), which was considered to be "required for the safe and competent practice of osteopathy" (General Osteopathic Council, 1998, p.2). Soon after, in 1999, the Standard of Proficiency document was revised (named the 'S2K' document), and made more explicit reference to the context and content of osteopathic practice (General Osteopathic Council, 1998). For example, the standard of 'Accountability' was added to emphasise the need for osteopaths to view themselves as autonomous professionals who are part of a wider healthcare community, such as G.Ps and other NHS healthcare services.

In 2012, the S2K document was further revised with an updated format (General Osteopathic Council, 2012a) incorporating both the standard of proficiency and the code of practice. The Osteopathic Practice Standards continue to play a central role in the requirements for osteopathic training and to enable existing practitioners continued

registration with the GOsC (General Osteopathic Council, 2012a). The GOsC (2012a) is required by law to ensure that all OEIs are obtaining the standards set out in the Practice Standards, ensuring the safe and competent practice of osteopathy. In order to safeguard this, in 2005 the GOsC successfully appointed the Quality Assurance Agency for Higher Education (QAA) to conduct reviews of OEI's curriculum and programmes of study (Quality Assurance Agency for Higher Education, 2011).

In 2007, the OEIs and the GOsC worked closely with the QAA to develop the Subject Benchmark Statement for Osteopathy. This is a QAA publication but it has been adopted by the GOsC providing more detailed guidance about osteopathic undergraduate education. Currently, the QAA reviews three main areas; clinical and academic standards (in line with the Osteopathic Practice Standards), the quality of learning and the effectiveness of teaching, and finally governance and management of the OEI concerned (Quality Assurance Agency for Higher Education, 2011). The main purpose of the QAA review is to enable the GOsC to make recommendations on approval to the Privy Council, (as in the RQ process) and to assure itself more generally that OEIs and the programmes they provide operate effectively (Quality Assurance Agency for Higher Education, 2011). The GOsC recently held a consultation on Guidance for Osteopathic Pre-regulation Education, which set out in detail the professional expectations of graduates meeting the Osteopathic Practice Standards<sup>5</sup>.

### 1.3.2. Development of the National Council of Osteopathic Research (NCOR)

The establishment of the National Council of Osteopathic Research (NCOR), in 2003, was an important development from the perspective of building the profile of osteopathy NCOR<sup>6</sup> was set up to work with OEIs, the GOsC and practicing osteopaths to help facilitate the development of osteopathic research (National Council for Osteopathic Research, 2013). Since its conception NCOR has carried out several research projects including developing and piloting a Standardised Data Collection tool (Fawkes et al., 2013), contributing to the 'Adverse Events Studies' commissioned by the GOsC (Leach et al., 2011) and research exploring patients' expectation of osteopathic care (Leach et al., 2013). Several OEIs followed in the drive to promote research and postgraduate learning, and some OEIs

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<sup>5</sup> [http://www.osteopathy.org.uk/uploads/draft\\_guidance\\_on\\_osteopathic\\_pre-registration\\_education\\_2014.pdf](http://www.osteopathy.org.uk/uploads/draft_guidance_on_osteopathic_pre-registration_education_2014.pdf)

<sup>6</sup> <http://www.ncor.org.uk/>

currently offer postgraduate degrees courses in osteopathy to Master's and Doctoral level (for example, British College of Osteopathic Medicine, 2013b; British School of Osteopathy, 2013; College of Osteopaths, 2013). NCOR, for example, recently produced a document summarising evidence in relation to osteopathy<sup>7</sup>, and has played a key role in shaping research priorities and helping develop research skills in osteopathy.

### 1.3.3. Inclusion in the NICE Guidelines for early management of non-specific low back pain

As the profession continues to grow, with in excess of 4900<sup>8</sup> currently on the GOsC register, osteopathy is moving towards playing a more substantial role in the British healthcare system. For example, in May 2009, the National Institute for Health and Clinical Excellence (NICE) published guidelines to improve the early management of non-specific low back pain in the UK (National Institute for Health and Clinical Excellence, 2009). The guidelines include osteopathic treatment as a form of manual therapy to be recommended to patients with non-specific low back pain of between 6 weeks and 12 months duration (National Institute for Health and Clinical Excellence, 2009). This was considered to be a significant acknowledgment of the value of osteopathy, and has the potential to enhance patient care by enabling practitioners to evaluate their practice against the NICE guidelines using published audit support tools (Vogel, 2009).

### 1.3.4. Introduction of Fitness to Practice Reports

To support the standards of practice, in 2001 the GOsC began publishing annual reports which provide information of complaints against osteopaths in relation to their fitness to practice. GOsC define an osteopath's 'fitness to practise' as having the 'knowledge and skills to perform their job effectively, they should have the health and character to practise safely and competently, and they can be trusted to act legally and responsibly' (GOsC, 2013). It should be noted that this process, as specified in law, is solely about assessing osteopaths' fitness to practice, and not about awarding compensation to patients or others who have been adversely affected by osteopaths. Specifically, the reports provide details of the: name, registration number of the osteopath concerned and the date of the Professional

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<sup>7</sup> [http://www.ncor.org.uk/wp-content/uploads/2013/05/Osteopathy\\_summary\\_May\\_2013.pdf](http://www.ncor.org.uk/wp-content/uploads/2013/05/Osteopathy_summary_May_2013.pdf)

<sup>8</sup> <http://www.osteopathy.org.uk/information/about-osteopathy/>

Conduct Committee (PCC) decision; the source of complaint, the summary of allegations found and finally the proved outcome and sanctions applied (GOsC, 2013). GOsC's 'Fitness to Practise' schemes have been based upon a series of consultations with the profession. For example, in October 2013, the GOsC opened a consultation to explore the views of the profession and other stakeholders on the length of time that they should actively publicise certain decisions of the PCC.

#### 1.3.5. From Revalidation to Demonstrating 'Continuing Fitness to Practise'

Following the publication of the 2007 Government White Paper *'Trust, Assurance and Safety'* (see Appendix containing a literature review relating to professional regulation and revalidation for more information), which required regulators to introduce schemes of 'revalidation'<sup>9</sup> for all healthcare professionals (General Osteopathic Council, 2009b), a major project for the GOsC has been to develop a scheme for demonstrating Osteopaths' 'Continuing Fitness to Practise', which the GOsC aims to be implemented in 2014 (General Osteopathic Council, 2012b).

In consultation with the osteopathy profession and other stakeholders, GOsC began a 'pilot' revalidation scheme with a number of volunteer osteopaths between September 2011 to September 2012, which consisted of the four domains of 'professionalism', 'communication and patient partnership', 'safety and quality in practice' and 'knowledge, skills and performance' (General Osteopathic Council, 2009a).

GOsC commissioned the professional services firm KPMG to conduct an independent assessment of the pilot revalidation scheme. KPMG's reports (2012a; 2012b)<sup>10</sup> were published in February 2013 (General Osteopathic Council, 2013), which discussed the nature of osteopathic practice and regulation, reported on the potential costs, risks and benefits of the GOsC revalidation scheme, and gathered feedback from revalidation pilot participants, including the time required to complete the scheme, the accessibility of the scheme to osteopaths, use and cost of assessing portfolios and merging the revalidation requirements

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<sup>9</sup> The report of the Government's Non-medical Revalidation Working Group outlined twelve principles that revalidation schemes should meet including 'quality', 'continued professional development' and public involvement (General Osteopathic Council 2009b).

<sup>10</sup> KPMG, 2012, *Final Report of the Evaluation of the General Osteopathic Council's Revalidation Pilot*: Available at: [http://www.osteopathy.org.uk/uploads/kpmg\\_revalidation\\_pilot\\_evaluation\\_report.pdf](http://www.osteopathy.org.uk/uploads/kpmg_revalidation_pilot_evaluation_report.pdf)

with a model of CPD. One of the key findings of the KPMG report was that, while pilot participants believed revalidation had potential to help them reflect on and improve their osteopathic practice, they found the pilot revalidation scheme overly complex, bureaucratic and time consuming, which undermined their motivation to engage with a revalidation process.

In response to the reactions to the revalidation pilot, including the KPMG (2012a; 2012b) reports, the GOsC revised its plans for revalidation. Following further consultation with key osteopathic stakeholders in various meetings, including the British Osteopathic Association (BOA), the Council for Osteopathic Educational Institutions (COEI), National Council for Osteopathic Research (NCOR), the Osteopathic Alliance (OA), OEIs, special interest groups, patients, the Professional Standards Authority and other regulators, the GOsC developed a new revised model for assuring 'Continuing Fitness to Practise' (CFtP). The GOsC outlined a new draft model of Continuing Fitness to Practise in 'Item 10' of a Report to the GOsC Council on 17<sup>th</sup> October 2013 (and consequently in *The Osteopath*, Dec 2013/Jan 2014, p.6-7), as well as its plans to carry out a further consultation about the model throughout 2013-4 and then approve and publish proposals for the regulation of CFtP at the end of 2014.

The report summarised the process as follows:

1. The process to assure Continuing Fitness to Practise comprises the following elements:
  - a. Evidence of 30 hours of CPD and 15 hours learning with others to be declared annually. This will total 90 hours of CPD with at least 45 hours learning with others over the proposed three year cycle of the Scheme.
  - b. The majority of CPD will continue to be self-directed. However, as part of the total 90 hours, at the end of each three year cycle, CPD activities must have been completed in each of the following areas of the *Osteopathic Practice Standards*: Communication and patient partnership; knowledge, skills and performance; safety and quality in practice; and professionalism.
  - c. All osteopaths will need to undertake at least one defined activity that focuses on consent and communication.
  - d. At the start of each three year cycle, osteopaths should undertake at least one of the following: peer discussion (including patient notes) and analysis; patient

feedback and analysis; clinical audit and analysis; or case-based discussion (including patient notes) and analysis.

- e. 'Peer Discussion Review' at the end of each three year cycle, there must be a peer discussion involving a review of the registrant's CPD Record. It is expected that the CPD Record would demonstrate the standards for CPD (see Appendix 1). The 'peer discussion review' must be documented (see below) and take account of the registrant's current level of knowledge, skill, area of practice and experience, any learning that they have completed and the registrant's analysis of their own learning needs which may lead to future action.

The peer review may be undertaken:

- i. By a professional colleague (either an osteopath or other healthcare professional)
  - ii. Within arrangements put in place by: A regional society or group; A member of the Osteopathic Alliance or other postgraduate CPD provider; An osteopathic educational institution; An employer
  - iii. By the General Osteopathic Council (GOsC).
- f. Standards – the peer review discussion would take place using the CPD standards. Examples of the standards that might be in place are attached at Appendix 1. An example of a cycle complying with the standards is attached at Appendix 2.
  - g. Quality Assurance – peer discussions that take place through organisations other than GOsC will be subject to quality assurance

The new CFtP scheme appears to take a more relational, professionally oriented, and less bureaucratic approach than the revalidation pilot, referring to feedback from the revalidation pilot and KPMG's (2012a) report, which osteopaths are more likely to buy into. The Report also noted the GOsC's objectives: To promote public and patient safety through proportionate, targeted and effective regulatory activity; to encourage and facilitate continuous improvement in the quality of osteopathic healthcare; and to use our resources efficiently and effectively, ensuring registrants are able to demonstrate their continuing ability to meet the *Osteopathic Practice Standards* and are encouraged continually to

enhance and improve their practice. Thus the new CFtP scheme aims to balance increasing registrant engagement with the process, while meeting GOsC's statutory requirements.

The Report, drawing upon a Professional Standards Authority report on '*assuring continuing fitness to practise based on right-touch regulation principles*'<sup>11</sup> (see Appendix 2 containing a literature review on professionalism, regulation, revalidation and continuing fitness to practise for more discussion of this report), discussed environmental risk factors, including lack of clinical governance, levels of autonomy and isolation, high levels of 'sexual invasiveness', levels of support provided (or not), emotional and psychological engagement and noted that a high proportion of osteopaths worked unsupervised, and often alone with patients and few work in hospitals or clinics subject to NHS standards for clinical governance. However the report also drew attention to the context in which osteopathic practice and regulation occurs, noting the relatively low risk associated with osteopathic practice, although 'major events' do rarely occur<sup>12</sup>, that osteopathic patients reported high levels of satisfaction<sup>13</sup> and that the level of complaints reported to the GOsC was relatively low<sup>14</sup>. On this basis the CFtP scheme appears to be able to take a relatively 'light touch' approach.

The Report discusses the importance of the CFtP scheme supporting 'genuine reflection', 'peer review' and 'feedback', with specific focus on 'consent and communication'. It notes that: in a profession practising primarily independently the efficacy of the scheme requires not just the involvement of the regulator but also of the osteopathy profession in order to demonstrate standards and enhanced quality of care. Thus the 'scheme will require capacity building within the osteopathic profession – among individuals and professional groups – to support learning, to support safe practice and continued enhancement of practice' and that 'networks are strengthened and professional isolation is reduced.'

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<sup>11</sup>Professional Standards Authority Report November 2012, *An approach to assuring continuing fitness to practise based on right-touch regulation principles* at: <http://www.professionalstandards.org.uk/docs/psa-library/november-2012---right-touch-continuing-fitness-to-practise.pdf?sfvrsn=0>

<sup>12</sup> See Vogel S. et al, *Clinical Risk Osteopathy and Management Summary Report, (the CROaM study)* 2012, p25, available at [http://www.osteopathy.org.uk/uploads/croam\\_summary\\_report\\_final.pdf](http://www.osteopathy.org.uk/uploads/croam_summary_report_final.pdf) accessed 30 September 2013.

<sup>13</sup> See Leach J. et al, *The OPEN project, investigating patients' expectations of osteopathic care Summary Report, (the Patient Expectations Study)*, 2011, available at: [http://www.osteopathy.org.uk/uploads/open\\_summary\\_report%20public.pdf](http://www.osteopathy.org.uk/uploads/open_summary_report%20public.pdf); accessed 30 September 2013

<sup>14</sup> See for example the CHRE/PSA Performance Review Reports for 2011/2012 and 2012/2013 available at: <http://www.professionalstandards.org.uk/docs/scrutiny-quality/chre-performance-review-report-2011-12.pdf?sfvrsn=0> and <http://www.professionalstandards.org.uk/docs/scrutiny-quality/performance-review-report-2012-13.pdf?sfvrsn=0> and accessed on 1 October 2013.



The report points to evidence (See McGivern & Fischer 2012) that registrants would be more likely to share data about and discuss their practice, leading to an enhancement of quality of care, in 'safer spaces' with professional colleagues than with the regulator. The scheme was therefore designed to demonstrate that participants were meeting the *Osteopathic Practice Standards* while remaining 'primarily self-directed by the osteopath, with some additional elements planned in over a period of three years to strengthen links to the *Osteopathic Practice Standards*'. The Report suggested that the peer review discussion element of the CFtP scheme could be delivered by people, groups or organisations outside of the GOsC supported by appropriate governance and quality assurance arrangements.

Therefore the proposed CFtP scheme takes an approach that appears to encourage professional ownership and engagement in improving the quality of osteopathic care, while also meeting GOsC's statutory responsibilities; supporting safe care and improving standards of care; developing the osteopathic professional community to support peer discussion amongst osteopaths about safety and quality of care; encourage reflection, learning and development of practice, inter-professional relationships, and awareness and integration of current research. While the scheme is based on 'CPD and reflection linked to the *Osteopathic Practice Standards* and areas of personal interest' it also aims to 'enable areas of concern identified through research or fitness to practise data' and thus to enhance compliance in these areas.

Table 3 summarises the major events pertaining to the development of osteopathy in the UK.

### **Osteopathic timeline**

- 1828-** Founder of osteopathy Dr Andrew Taylor Still born, Virginia, USA
- 1874-** 22<sup>nd</sup> June, A. T. Still “Flung to the breeze the banner of Osteopathy”
- 1892-** A. T. Still opened first school of osteopathy (the American School of Osteopathy)
- 1902-** First American trained osteopaths arrive in the UK
- 1903-** The British Osteopathic Society formed
- 1910-** Formation of the British Osteopathic Association
- 1913-** Littlejohn returns permanently to the UK
- 1917-** First UK osteopathy school, the British School of Osteopathy, established in London
- 1936-** Formation of the General Council and Register of Osteopaths (GCRO)
- 1989-** The King’s Fund consider the scope and content of legislation to regulate osteopathy
- 1993-** Passing of the Osteopaths Act and formation of the General Osteopathic Council
- 1998-** GOsC publish Standards of Proficiency document (S2K)
- 2000-** Osteopaths Act comes into force, the title of ‘Osteopath’ becomes legally protected
- 2003-** National Council for Osteopathic Research (NCOR) is formed
- 2009-** Osteopathy included in NICE ‘management of non-specific low back pain’ guidelines
- 2010-** First Professional Doctorate in Osteopathy launched
- 2012-** Revised Osteopathic Practice Standards
- 2012-** Piloting of the Revalidation Scheme for Osteopaths
- 2013-4-** Fitness to Practice Consultation around new draft Continuing Fitness to Practise model
- 2014 -** Consultation on the Guidance for Osteopathic Pre-registration Education

Table 3: Timeline of historically significant events of osteopathy in the UK (modified from Evans, 2007)

## **Part 2- The practice of osteopathy in the UK**

Osteopathic practice is considered to be embedded within a framework of concepts and principles. It is thought that the osteopathic principles can be woven into the clinical practice of individual osteopaths. Knowledge of the inter-relatedness of the osteopathic principles is believed to facilitate practitioners to make diagnostic, treatment and management decisions with their patients. Although there is limited research of the nature of osteopathic practice and delivery of osteopathic care, there has been no shortage of theoretical models detailing osteopathic assessment procedures and the application of osteopathic manipulative therapy (OMT). Since the early days of osteopathy, practitioners have used a range of therapeutic techniques, with the osteopathic principles underpinning their application. The range of specific therapeutic approaches and techniques appears to have resulted in distinct (although informal) sub-disciplines, and currently OMT is applied to: the neuro-musculoskeletal system, often called 'structural osteopathy' (for example, Gibbons and Tehan, 2009); internal organs, called 'visceral osteopathy' (for example, Barral and Mercier, 2005) and applied to the skull, called cranial osteopathy<sup>15</sup> (for example, Liem et al., 2004), and also treatment models developed by specific and influential individuals, such as 'Classical Osteopathy' (for example, White, 2000), which was devised by Littlejohn and later by his student John Wernham.

### **2.1 Scope of practice**

It is worth noting that osteopathy throughout the world has taken different paths over the course of the time period, with the most marked difference being between British and American trained osteopaths. Osteopaths in the USA are licensed to practice the full scope of medicine, including surgery and the prescription of medications. In the UK, osteopaths are described (rather than defined) as autonomous manual therapy professionals, focused on the diagnosis, treatment, prevention and rehabilitation of musculoskeletal disorders, and the effects of these conditions may have on patients' general health (General Osteopathic

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<sup>15</sup> *Cranial osteopathy* endorses the concept of 'involuntary motion', which is described as a motion which passes throughout the entire body (not just the skull), and is separate from other forms of voluntary motion such as locomotion or respiration (Stone 2002). However, cranial osteopathy has attracted a degree of controversy from some parts of the osteopathic profession due to, what some describe as 'biologically outlandish' claims of its mechanism which has no 'scientific basis' (Hartman 2005; 2006).

Council, 2010b). Research by Johnson and Kurtz (2001) illustrate these differences in scopes of practice between American-trained and UK-trained osteopaths. Their research found that the vast majority of American osteopathic physicians employed osteopathic manipulative therapy (OMT) on less than 5% of their patients, and instead preferred to use more traditional medical interventions such as pharmaceutical treatments and surgical procedures. In comparison osteopaths in the UK perform OMT on 80% of patients during their first appointment (Fawkes et al., 2010). This appears to provide evidence of the diminished use of hands-on manual therapy amongst American osteopathic practitioners, and illustrates a major difference compared UK osteopaths.

## **2.2 Defining osteopathy**

Even since the times of A. T. Still, osteopathy has grappled with a unifying definition, which could incorporate its philosophical principles and broad range of therapeutic techniques. Even today it has been said the profession is still yet to fully define itself or its core set of professional values (Tyreman, 2008). From an international perspective, osteopathy has been defined by the World Health Organisation (WHO) as:

‘A system of medicine that emphasises the theory that the body can make its own remedies, given normal structural relationships, environmental conditions, and nutrition. It differs from allopathy primarily in its greater attention to body mechanics and manipulative methods in diagnosis and therapy.’

(World Health Organisation, 2010, p.43)

In the UK, the GOsC describe (rather than define) osteopathy as:

‘A system of diagnosis and treatment for a wide range of medical conditions. It works with the structure and function of the body, and is based on the principle that the well-being of an individual depends on the skeleton, muscles, ligaments and connective tissues functioning smoothly together.’

(General Osteopathic Council, 2010b)

The first definition provided by the WHO, the overarching organisation of health professions throughout the world, implies that osteopathy is a complete 'system of medicine', and is arguably more consistent with the original ideas of its founder A. T. Still, as discussed in the previous section of this review. This definition may have largely come about from the extended practice rights of American osteopaths. More relevant to this review is the second description provided by the governing professional body in the UK, the GOsC. This definition reflects the relatively limited scope of practice of UK practitioners, and places osteopathy within the field of manual-physical therapy with a strong emphasis on the neuro-musculoskeletal system, rather than a total system of medicine and healthcare.

### **2.3 The professionalisation of osteopathy in the UK**

This section provides additional context, and overviews osteopathy's development as an emerging profession within the healthcare landscape. A 'profession' may be considered to be an occupational group with a discrete knowledge base (Richardson et al., 2004), that must demonstrate the "ability to successfully engage in self-directed and lifelong learning, to contribute to the knowledge base of the profession and to practice in a manner which demonstrates professional autonomy, competence and accountability" (Cant and Higgs, 1999, p.46). Freidson (1970a; 1970b; 1994) argues that professional autonomy and self-regulation is justified on the basis of 'technical and moral authority'; the idea that only professionals are capable of fully understanding their practice and can be trusted to act in the interests of patients and the public, rather than their own (also see other appendix relating to regulation and revalidation for a more detailed discussion of professionalism).

Osteopathy, like many other complementary therapies, can be seen as having undergone a process of 'professionalisation', with the major events discussed earlier in this review. Cant and Shamar view 'professionalisation' as a "type of occupational change and formation that involves unification, standardisation, and the acquisition of external legitimacy" (Cant and Sharma, 1996, p.157). They consider that the process of transforming a complementary therapy into a profession requires the group to engage in five major strategies; unification, codification of knowledge, social closure (limiting the number of practitioners and instituting stringent training programmes), and alignment to the scientific paradigm and support from strategic elites (Cant and Sharma, 1996).

As osteopathy may be considered a complementary therapy, it is noteworthy to consider its professionalisation in view of these strategies of transformation and is discussed below.

**1) Unification-** As outlined previously in Section 1.2.1 the formulation of a single statutory register of osteopaths and extending the level of training and standards provides a degree of unity to the osteopathic profession. Registration with the GOSc is compulsory for practice. **2) Codification of knowledge-** Structured training programmes which have been awarded recognised qualification status (RQ) by the GOSc, and research illuminating areas of osteopathic practice have begun to develop the knowledge base of the profession. The findings from this research contribute to this process; **3) Social closure-** Osteopathy now has strictly regulated training courses, a legally protected title of 'Osteopath' and measures in place to discredit those practitioners who do not practice to agreed standards. These measures help provide osteopathy with exclusivity and social closure; **4) Alignment to the scientific paradigm-** The role of science in osteopathy has been debated, and some claim that since its conception osteopathy has always endeavoured to incorporate science into its practice (Lucas and Moran, 2007). While scientific knowledge constitutes just one form of knowledge necessary for practice, it is this type of knowledge that is considered a 'higher level' of evidence within the current model of evidence based medicine (Sackett, 2000). However, scientific research methods such as the randomised control trial (RCT) are required to explore specific aspects of professional healthcare practice, such as the therapeutic effectiveness of osteopathic treatment interventions (for example, UK BEAM Trial, 2004; Licciardone et al., 2013). From this perspective, osteopathy has begun to engage with the scientific paradigm through a number of measures. The profession now produces and publishes research papers in osteopathic and non-osteopathic peer-reviewed journals, holds annual conferences in advances in osteopathic research and has developed its training courses (postgraduate and undergraduate) to incorporate the science-based subjects such as biomechanics, physiology and anatomy and also includes scientific research method modules within its undergraduate training courses. Furthermore, the establishment of a dedicated osteopathic research council in the form of NCOR (National Council for Osteopathic Research, 2013) provides a useful resource for members of the osteopathic profession to access scientific research and evidence to help inform clinical practice. **5) Support from strategic elites-** In the UK, osteopathy has received support from the medical profession in the form of the National Institute for Clinical Excellence (National Institute for

Health and Clinical Excellence, 2009), and also support from the state by way of The Houses of Parliament (The Osteopaths Act, 1993).

Taken together, these features suggest osteopathy can be seen as engaged positively in the project of professionalisation. However, Richardson (1999) explains that a profession needs to be accountable, autonomous and its members need to be willing to interact and adapt to changes in practice and politics. Having 'professionalised' itself, osteopathy is required to maintain its professionalism by way of a commitment to the task and maintenance of standards and ethics via a code of practice and continued life-long professional learning and development of its members, such as those set out in the current Osteopathic Practice Standards and Code of Practice (General Osteopathic Council 2012a). However a profession is also required to be critical and reflective, constantly evaluating, questioning and developing its knowledge base and practice and further professional, educational and clinical research is required to facilitate the maturation of the osteopathic profession in the UK.

#### **2.4 The current status and nature of osteopathic clinical practice**

Over the last decade, osteopaths are increasingly being considered as significant providers of manual therapy especially for the management of non-specific low back pain (National Institute for Health and Clinical Excellence, 2009). Osteopaths in the UK are autonomous practitioners who require a broad ranging knowledge and skill base in order to diagnose and manage patients with a range of musculoskeletal and non-musculoskeletal conditions presented in practice (General Osteopathic Council, 2001; Fawkes et al., 2013). About half of UK osteopaths practice alone (KPMG 2012b; Opinion Matters 2012). With regards to presenting symptoms, spinal pain is by far the most common condition treated by osteopaths (General Osteopathic Council, 2001; Fawkes et al., 2013). A survey conducted by the GOsC in 2006 suggests that approximately 30,000 people consult osteopaths every working day (General Osteopathic Council, 2010b; General Osteopathic Council, 2012c).

Recent research conducted by the National Council for Osteopathic Research (NCOR) has generated data on osteopathic practice in the UK (Fawkes et al., 2013). Whilst the primary aim of this research was to pilot test and further develop a 'standardised data collection tool' which eventually could be used to collect data from practicing osteopaths on a national

level, the research generated a preliminary insight into osteopathic practice in the UK, including areas such as 'patient demographics', 'patient symptom profile', 'osteopathic patient management', 'treatment outcomes' and 'financial implications of care' (Fawkes et al., 2013). Although only 342 practitioners (9.4% of the UK profession) participated in the NCOR research study, the findings suggest that the osteopathic treatment provided were "varied and complex" as evidenced by the wide range of treatment and management interventions used by participants including manual therapy, exercise, educational advice and acupuncture (Fawkes et al., 2013, p. 10). The findings also showed that for the vast majority of patients (79.9%), the route to osteopathic care was self-referral (Fawkes et al., 2013), many of which (69.8%) sought treatment from a particular practitioner via 'word-of-mouth' (Fawkes et al., 2013). The national pilot study conducted by Fawkes et al (2013) also suggested that the financial responsibility for treatment was met by individual patients in 90% of cases, which appear to support the results from the GOsC survey which shows that osteopathy remains largely a form of private healthcare with more than 80% of patients funding their own treatment (General Osteopathic Council, 2012c)(KPMG 2012b) .

Osteopaths employ a broad spectrum of therapeutic interventions, with 'hands-on' manual therapy techniques (such as joint mobilisation and spinal high-velocity thrust manipulation) as the preferred form of treatments modalities for practitioners in the UK (General Osteopathic Council, 2001; Fawkes et al., 2013) as well as internationally (Johnson and Kurtz, 2003; Orrock, 2009). A 2001 survey of the UK osteopathic profession conducted by the GOsC (2001), showed that almost 75% of responders regularly used joint mobilisation techniques, and almost 50% regularly used high-velocity thrust techniques, as part of their treatment, and similar statistics are supported by more recent research (Fawkes et al., 2013). In light of the relatively wide ranging use of joint mobilisation and manipulation by osteopaths and other manual therapy professions (chiropractors and physiotherapists) there has been and continues to be intense medical and scientific debate regarding the safety of spinal manipulation techniques, particularly when applied to the cervical spine (for example, Ernst, 2002; Ernst, 2007; Cassidy et al., 2012; Wand et al., 2012). Much of the research literature on the safety and 'adverse events' associated with manual therapy has been conducted by the physiotherapy and chiropractic professions, and little data is available in relation to manual therapy applied by osteopaths. In response to this knowledge-gap and with the aim to gain a better understanding of any potential risk that



may be associated with osteopathic care, the GOsC funded four interlinked research projects, and are summarised in Table 4. (CHECK FONT SIZE FOR TABLE BELOW)

Authors and year	Project title	Project aims	Research approach	Participants	Major findings and conclusions
Carnes et al (2010a)	Adverse events associated with physical interventions in osteopathy and relevant manual therapies	To explore the incidence and risk of adverse events with manual therapies	Systematic review	Eight prospective cohort studies and 31 manual therapy RCTs were accepted	The risk of major adverse events with manual therapy is low, but around half manual therapy patients may experience minor to moderate adverse events after treatment. The relative risk of adverse events appears greater with drug therapy but less with usual care.
Carnes et al (2010b)	Defining adverse events in manual therapies	To seek an expert consensus definition of adverse events in relation to manual therapy by exploring understanding and meaning	Modified Delphi consensus study	Expert panel (n=50) consisting of: osteopaths, chiropractors and physiotherapists; Secondary care clinicians; pharmacists, G.Ps and researchers internationally	Development of a classification system for adverse events: <b>'Major' adverse events</b> are medium to long term, moderate to severe and unacceptable, they normally require further treatment and are serious and distressing; <b>'Moderate' adverse events</b> are as 'major' adverse events but only moderate in severity; and <b>'Mild' and 'not adverse' adverse events</b> are short term and mild, non-serious, the patient's function remains intact, and they are transient/reversible; no treatment alterations are required because the consequences are short term and contained.
Leach et al (2011)	Communicating risks of treatment and	To investigate the frequency and character of complaints made by	Preliminary literature review:	Anonymised complaints records;	Findings resulted in recommendations for future monitoring of complaints and the

	informed consent in osteopathic practice	patients about osteopathic care, To gain a greater understanding of the nature of the complaint and the circumstances leading to complaints.	quantitative document analysis; qualitative thematic analysis.	individuals acting as intermediaries and advisers to osteopaths/patients during a complaint.	identification of priorities for future research: including developing and testing the new classification system; improving on the quality and accuracy of the routinely collected data to assist in evaluation of outcomes; and utilising further sources of quantitative and qualitative data.
Vogel et al (2012)	Clinical Risks Osteopathy and Management (CROaM)	To investigate osteopaths' attitudes to managing and assessing risk in clinical settings and patients' experiences and responses to osteopathic treatment	Mixed methods (surveys, interviews)	Patients ( $n=2,057$ ) and osteopaths ( $n=1,082$ )	Serious adverse events following osteopathic care are rare, but do occur. No link between any specific treatment technique (e.g. neck manipulation) and adverse events.

Table 4. Adverse events research studies commissioned and funded by the GOsC

Together, these research projects explored the safety of osteopathy and adverse events associated with osteopathic care from the perspectives of patients, practitioners, researchers and insurance companies and provided valuable research-based knowledge which could help inform future guidelines and codes and standards of practice set out by the GOsC and subsequently osteopathic education curriculum and CPD courses.

## 2.5 Evidence-based practice and osteopathy

Since the 1980s there has been an escalating move away from clinical practice that is guided purely by belief and tradition, to one informed by research evidence. While the philosophical foundations of evidence-based practice (EBP) date back to the mid-19<sup>th</sup> century (Sackett et al., 1996), a significant driving force was the initiation of the Department of Health Quality Agenda in 1998 (Department of Health, 2000), which in part sought to enhance standards of healthcare practice in the UK by the encouragement of lifelong learning for health professionals. The evidence-based practice 'movement' has reached most corners of the world (Kitson, 2001; Zaidi et al., 2009) and the EBP model is upheld as

the optimal practice philosophy in many healthcare professions, including Medicine (Sackett, 2000) and Physiotherapy (Herbert et al., 2001; Portney, 2004; Ross and Anderson, 2004).

The osteopathic profession has not escaped the EBP debate, with many researchers in agreement that some form of EBP needs to be integrated into the osteopathic approach (for example, Vogel, 1994; Green, 2000; Fryer, 2008; Leach, 2008; Licciardone, 2008). It has been posited that a more appropriate term is 'evidence-informed osteopathy', as it rightly acknowledges that research evidence should not replace practice, rather it should inform and guide it (Green, 2000; Fryer, 2008).

However, what 'counts', as evidence is intensely contested, (Gibson and Martin, 2003; Henderson and Rheault, 2004; Rycroft-Malone et al., 2004), with qualitative research (such as this current research study) not considered as part of the accepted EBP model. Overall, there is mounting discontent with the EBP model as it stands across a number of different healthcare professions, including medicine (Hancock and Easen, 2004; Mykhalovskiy and Weir, 2004; Porta, 2004; Rosenfeld, 2004; Tonelli, 2006) and physiotherapy (Bithell, 2000; Herbert et al., 2001; Shaw et al., 2010) and EBP continues to be debated within the osteopathic profession. Owing to the complexities of the manual therapy interventions, one major concern is that an overemphasis on the use of RCTs and an overreliance on the knowledge generated from these methods, are unlikely to develop the well-rounded and robust knowledge base necessary for osteopathy (Milanese, 2011; Thomson et al., 2011; Petty et al., 2012).

There are also a number of professional barriers which may challenge the development of an evidence-based culture within osteopathy. For example, osteopathic practitioners in the UK appear to be concerned that the implementation of EBP will fail to preserve the osteopathic principles and threaten the profession's uniqueness (Humpage, 2011). Another barrier may be the philosophical differences between osteopathy and EBP. In light of osteopathy being considered a patient-centred approach to healthcare (Stone, 1999; Butler, 2010), there may be a number of challenges when marrying together both patient-centred and evidence-based models of practice. One major issue is that the RCT is designed for a biomedical model of healthcare, and it sits toward the top of the evidence hierarchy (Sackett, 2000). The RCT assumes homogeneity of patients, and fails to recognise the

individuality of the patient and their illness experience, which is one of the central pillars of the patient-centred care model (Mead and Bower, 2000). Therefore, there appears to be a tension between osteopaths wanting to adopt a patient-centred holistic model of care in-line with proposed osteopathic models of practice and pressure (both external and internal) on osteopaths to provide evidence-based healthcare.

## **2.6 Summary**

The diverse professional, educational and political history of osteopathy, spanning across three centuries have shaped the professions' current status and practice today. This review has considered the progression of osteopathy to a regulated healthcare profession, and provides a picture of the range of approaches taken in modern-day osteopathy. This review provides context to the reader and facilitates researchers' theoretical sensitivity when exploring the nature and dynamics of osteopathic regulation, professionalism, and compliance with standards in practice.

Document	Date	Author	Claimed purpose	Outcome
Research Amongst Registered Osteopathic Practices	1987	Medicare Research Ltd (Commissioned by the Genesis Osteopathic Foundation)	To provide a detailed picture of how osteopathy was developing as a profession in the UK to help inform and to gain parliamentary support for osteopathy.	From the 250 practitioner responses, and 1110 patient case history files, the research identified previously unknown aspects of the osteopathic profession and osteopaths' clinical practice, including practitioner and patient characteristics, the nature of osteopathic clinical practice (e.g. treatment, management, clinical examination and diagnostic approaches).
Kind's Fund Working Party Report on Osteopathy	1991	King's Fund (Chaired by Rt Hon Sir Thomas Bingham)	Devise a fair and practical means of achieving regulation of the osteopathic profession in the UK and propose a fair system of statutory regulation for osteopaths and one which satisfies all the conditions and recommendations set by the UK government.	As a result of the Working Party consulting the osteopathic and medical professions, patient interest groups and other statutorily regulated professions the King's Fund recommendations draft Osteopaths Bill proved acceptable to Parliament and ultimately led to the passing of the Osteopaths Act in 1993.  Formed the basis for first Standards of Proficiency (1999) document for osteopathy.
Osteopaths Act	1993	UK Act of Parliament	An Act to establish a body to be known as the General Osteopathic Council; to provide for the regulation of the profession of osteopathy, including making provision as to the registration of osteopaths and as to their professional education and conduct; to make provision in connection with the development and promotion of the profession; and for connected purposes.	The Osteopaths Act provides powers to the GOsC to:  <ul style="list-style-type: none"> <li>- Set and maintain standards of osteopathic practice and conduct</li> <li>- Maintain a Register of qualified professionals</li> <li>- Assure the quality of osteopathic education and training</li> <li>- Help patients with complaints about an osteopath</li> <li>- Remove from the Register anyone who is unfit to practise</li> </ul>
Standards of Proficiency  Revised Standards of Proficiency (S2K)	1998  2000	General Osteopathic Council	To ensure that osteopaths registering with the General Osteopathic Council will be practising to this Standard.	Explicit guidelines for practice for the safe and competent practice of osteopathy which could be further developed in accordance with changing healthcare demands.

The Code of Practice	2005	General Osteopathic Council	To provide advice and guidance on the practice of osteopathy and the principles of personal and professional conduct.	The Code of Practice was not a set of rules governing all aspects of conduct in every possible circumstance, but guidance based on principles that can be extended to most professional situations. Adhering to Code required practitioner to exercise professional judgement and accept personal responsibility of their patient care. The Code was also informed by values common to most if not all healthcare professionals.
Continuing professional development (CPD) guidelines for osteopaths	2005 (revised in 2010)	General Osteopathic Council	To maintain and enhance osteopaths professional work, knowledge. To facilitate practitioners to develop and identify strengths and weaknesses.	A framework which provides guidance for osteopaths about the implemented continuing professional development (CPD) scheme.
Handbook for the GOsC review of osteopathic courses and course providers	2005 (revised in 2011)	General Osteopathic Council; Quality Assurance Agency (QAA) for Higher Education	To explicitly outline how the QAA review method of osteopathic education providers will be operated.	A framework for ongoing review of osteopathic education providers wishing to apply for, or maintain the recognised qualification (RQ) status.
The Osteopathic Practice Standards (OPS)	2012	General Osteopathic Council	To ensure the standards of conduct and practice expected of osteopaths and to give advice in relation to the practice of osteopathy.	The Osteopathic Practice Standards comprised both the Standard of Proficiency and the Code of Practice for osteopaths. The OPS plays a central in the requirements for osteopathic training and the achievement and retention of registration with the General Osteopathic Council.

Table 5. Major documents which have contributed to the development of osteopathic regulation

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