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WARWICK BUSINESS SCHOOL

Exploring and explaining the dynamics of osteopathic regulation, professionalism and compliance with standards in practice

Report to the General Osteopathic Council

February 2015

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General Osteopathic Council

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THE BRITISH SCHOOL OF OSTEOPATHY

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Professor Gerry McGivern[1], Dr Michael Fischer[2], Dr Tomas Palaima[1], Zoey Spendlove[3], Dr Oliver Thomson[4] and Professor Justin Waring[3]

[1]Warwick Business School, University of Warwick, UK.

[2]Centre for Workplace Leadership, University of Melbourne, Australia, and Said Business School, University of Oxford, UK.

[3]Centre for Health Innovation, Leadership and Learning, Nottingham University Business School, University of Nottingham, UK

[4]British School of Osteopathy, UK.

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Executive Summary

Introduction and research aims

- This is a report on research conducted by an independent team of academics from the University of Warwick, the University of Melbourne/ University of Oxford, the University of Nottingham and the British School of Osteopathy, funded by the General Osteopathic Council (GOsC) to answer the research questions: What regulatory activities best support osteopaths to be able to deliver care and to practice in accordance with the Osteopathic Practice Standards (OPS)? What factors inhibit osteopaths from practising in accordance with OPS? What factors encourage osteopaths to practice in accordance with OPS?

Research methods

- We conducted literature reviews about osteopathic practice, the osteopathy profession and osteopathic regulation (see Appendix 1) and professionalism, health professional regulation, revalidation and continuing Fitness to Practise (FtP) generally (see Appendix 2) and analysed GOsC documentation to provide us with a background understanding of osteopathic regulation.

- We then developed interview questions and conducted semi-structured interviews with 55 people (including 37 osteopaths) involved in and affected by osteopathic regulation, as well as health professional regulation more generally. We analysed interviews using qualitative data analysis methods, including coding and template analysis. We present anonymised narrative extracts from interviews to illustrate and evidence the points we make in this report.

- We also ran an online survey (see Appendix 3), which 809 osteopaths completed (17% of the 4900 osteopaths on the GOsC register). We analysed the results of

the survey (see Appendix 4) conducting T-tests for statistically significant variations in responses among demographic groups. We also conducted an exploratory factor analysis of responses to questions, which indicated 10 factors (favouring formal peer review; favouring informal peer review; feeling compliant with standards; pro-evidence-based practice; pro-GOsC; fear-based compliance with standards; osteopathic distinctiveness; clarity about reporting colleagues' poor practice; experiential perceptions of GOsC; narrative perceptions of GOsC).

Osteopathic professionalism and practice

- Osteopaths use a range of approaches ranging from quasi-medical structural musculoskeletal manual therapy to osteopathy akin to esoteric healing. This diversity may make osteopathic regulation against standards more complex. Some interviewees said osteopathy and other manual therapies (such as physiotherapy or chiropractic) overlap, while others said osteopathy was a unique health care profession. In our survey, 84% of osteopaths agreed that 'osteopathy is a unique health care profession'. Most osteopaths we interviewed were proud of their professional identity as an osteopath and believed that osteopaths improve patients' health in a distinctive way, so should be regulated by an osteopathic rather than generic regulator.

- Most osteopaths practice independently or in small practices, often in isolation from other professional. Osteopaths, particularly those working alone, may have few opportunities to discuss their practice with colleagues and so become out of step with best practices. Yet other osteopaths may not know about their poor practice. Osteopaths also commonly practice as self-employed businesses, earning higher incomes by attracting more patients. Osteopaths therefore have an interest in collectively developing the quality and reputation of the osteopathy profession, while individually competing for patients with other osteopaths, which may create a disincentive to collaboration and openly discussing their practice with other osteopaths.

- Interviewees described osteopathy as a holistic, patient-centred manual therapy in which verbal and non-verbal communication and relations with patients, use of osteopaths' hands ('palpation'), subjective interpretations and intuition were important elements in diagnosing and treating patients. We suggest that the complexity of osteopathic practice make its regulation against standards more difficult.

- Many interviewees commented on the limited evidence of the risks and benefits of osteopathy, which was a source of professional insecurity. Yet osteopaths were also concerned that evidence should be developed in terms appropriate to osteopathy, rather than using a biomedical approach. While generally in favour of evidence-based practice in principle, osteopaths were less positive about its effects in their practice. The limited osteopathic evidence-base makes osteopathic regulation against standards more difficult.

Osteopaths' perceptions and experiences of standards

- Many osteopaths we interviewed believed that OPS provide a useful benchmark for good osteopathic practice. However others criticised OPS for simultaneously being too open to interpretation and also legalistic, bureaucratic and rigid. Osteopaths particularly complained about OPS relating to communicating risks associated with osteopathic treatments and gaining patient consent, note-keeping, and patient modesty and dignity.

- Some interviewees said they always thought about OPS, others that they thought about OPS unconsciously, a few commented that they rarely considered OPS, relying instead on their professional training. 19% of osteopaths in our survey *dis*agreed that 'What I do as an osteopath always fully complies with the OPS'. Interviews suggest that osteopaths judge compliance with standards using a "sense" rather than evidence. In our survey, more osteopaths said they complied with OPS 'to avoid getting into trouble with the GOsC' (49%) or 'being sued by a

patient' (54%) than because OPS 'reflect what it means to be a good osteopath' (28% agreed).

- Osteopathic Education Institutions (OEIs) map their curricula against OPS and seem to place emphasis on getting osteopathic trainees to internalise OPS and understand how they apply in practice. From our survey, recently qualified osteopaths were more likely to agree with osteopathic regulation and demonstrate 'fear-based compliance with standards' (from factor analysis).

Osteopaths' perceptions and experiences of the GOsC and osteopathic regulation

- Interviewees commented that the GOsC had significantly improved in recent years, largely because it had made effort to reach out and *personally* engage with osteopaths. Closer engagement between the GOsC and osteopaths seemed to have improved osteopaths' understand of OPS and belief in their legitimacy. However some osteopaths remained suspicious of the GOsC and questioned the legitimacy of the OPS due to problems and difficult relations between the GOsC and the osteopathy profession in the past, when new regulation was introduced. Our survey data suggests that osteopaths' perceptions of the GOsC are affected by the GOsC's communications, experiences of the GOsC and what osteopaths hear from their colleagues. Evidence from this study supports the GOsC's relational approach to actively engaging with the osteopathy profession, which we suggest is leading osteopaths to frame osteopathic regulation and complying with OPS in more constructive professional terms.

- We conducted interviews with two osteopaths subject to FtP hearings and a patient who made an complaint considered in an osteopathic FtP hearing. These interviews suggested that FtP hearings were fair and well managed but took too long. The patient was unhappy because they felt the FtP process had addressed issues that did not reflect their original complaint. Both the osteopaths described their FtP investigations and hearings as distressing, believed they should never have been subject to FtP hearings, and emerged from the process doubting the

validity of osteopathic regulation, rather than their own practice, and less professionally engaged.

- While based on a small sample, our interview findings echo previous research on experiences of osteopathic complaints (Leach et al. 2011; Moulton Hall, 2014). Our survey data also points to relatively low levels of understanding of and confidence in FtP hearings among osteopaths more generally. Interviews suggest that stories about damaging experiences of FtP hearings may produce anxiety about regulation and consequent defensive practice in the wider osteopathic population.
- While legislation provides the GOsC little discretion about whether to investigate osteopathic complaints, and serious complaints do need to be heard in FtP hearings, our findings suggest that the GOsC should aim to minimise the number of FtP hearings. Developmental professional processes, like peer discussion review, may proactively prevent potential osteopathic malpractice, complaints and consequent FtP hearings.

Osteopaths' worries and concerns about practice and how to address them

- Concerns about osteopaths' own practices were common. In our survey, 22% of osteopaths had worried about their practice not complying with the OPS. Osteopaths suggested that reflection, communication, sharing, learning and discussion with osteopathic colleagues were the most effective ways of addressing malpractice and maintaining high quality practice. However, many osteopaths lack such opportunities. Our research suggests a need for more reflective discussions between osteopaths in 'formative spaces' (McGivern and Fischer, 2012), where they feel safe to openly reflect on and discuss their practice. These would proactively reduce professional malpractice and isolation, engage osteopaths in professionalism and improve the overall standard of osteopathy.

- Concerns about colleagues' practices were also common. In our survey, 28% of osteopaths reported having had concerns about colleagues' practice or behaviour. While most osteopaths said they would report 'serious' concerns (involving sexual abuse, harm to patients or criminality) to the GOsC, our interview and survey data suggest that few concerns are reported, due to lack of solid evidence and not wanting to cause trouble for colleagues. Osteopaths seem more likely to discuss concern about an osteopath with other colleagues, to advise patients to make a complaint, speak to the osteopath they were concerned about, or, more worryingly, take no action.

Peer discussion review

- The introduction of 'peer discussion review' within the GOsC's process to assure osteopaths' continuing FtP provides an opportunity for reflective discussions in which osteopaths can address worries about their own practice and peer reviewers can raise concerns about osteopaths they review. In our survey, 52% of osteopaths agreed 'peer review, involving *informal* discussion of my practice with another osteopath, would have a positive effect' (only 34% agreed 'peer review would have a positive effect on how I practice as an osteopath' in general). 69% agreed they 'would be able to bring up problems and tough issues during a peer review involving *informal* discussion of my practice'. Osteopaths were more likely to agree with both statements if they are able to choose their peer reviewer.

- Our research supports the introduction of informal peer discussion review as part of the GOsC process to assure osteopaths continuing FtP. However, peer discussion reviews should be *confidential*. Unless *serious* concerns are raised the *content* of peer discussion reviews should not be formally recorded or reported to the GOsC, to encourage open reflection and discussion of problems.

- Some osteopaths used the language of 'red flags' (signalling serious concerns about osteopathic practice or professionalism) and 'yellow cards' (signalling less serious concerns). Other osteopaths complained about abstract, legalistic and educational language used in the GOsC's earlier revalidation pilot, which osteopaths struggled to understand or relate to. Explaining regulation using terms familiar to osteopaths may better communicate its purpose. 'Red flags' have a specific meaning in clinical contexts, which might not reflect the precise intension of osteopathic regulation, but the GOsC could consider using similar language when designing regulatory process. 'Red flags' need to be reported to and investigated by the GOsC, to protect patients and the public, but our interview and survey data suggest that 'yellow cards' may be better addressed between professionals during peer discussion reviews, as we will discuss below.

Promoting compliance with regulation

- Our research adds to evidence (Quick, 2011) suggesting that professionals are more likely to comply with regulation when they understand why regulation is necessary, the evidence underpinning the regulatory approach, believe regulation is legitimate, reflects and promotes good professional practice, and professionals have been involved in its development.

- Osteopaths need regulation aligned with wider societal norms to demonstrate their practice is a safe and legitimate and ensure ongoing demand from patients. Our research suggests that osteopathic regulation based on formative, informal and confidential 'peer discussion review' and CPD providing assurance of continuing FtP is 'right touch regulation' (PSA, 2010), balancing societal expectations and osteopathic practice. It is an approach likely to support compliance with the OPS, reduce malpractice and produce improvements in osteopathic practice overall.

Recommendations

On the basis of the findings of this research report, we make the following recommendations:

1. The GOsC should **encourage and support the development of more evidence relating to the benefits and risks of osteopathy**, conducted in terms appropriate to osteopathic practice, to provide a firmer basis for some OPS.

2. The GOsC should provide **further communication and training about the OPS**, particularly the standards osteopaths complained about most, relating to:
   - **Communicating risks and gaining consent from patients** – clarifying how osteopaths can communicate risks of osteopathic treatments to patients in ways that do not alarm them or undermine their confidence in osteopathy.
   - **Keeping patient notes** – addressing osteopaths' concerns about what constitutes adequate note-keeping and why notes are necessary.
   - **Patient dignity and modesty** – Clarifying what is expected in relation to these standards to prevent some osteopaths interpreting them in 'black and white' terms, which do not reflect the intent of the OPS and undermine their confidence in the OPS more generally.

3. **Our research supports the work the GOsC is doing in reaching out, personally engaging and improving relations with the osteopathy profession**. Our research suggests this is important in terms of staying in touch with osteopathic practice and the issues osteopaths are facing, demonstrating to osteopaths that the GOsC understands what they do and the challenges they face, and legitimating the GOsC and compliance with OPS within the osteopathy profession. Professional engagement seems to be changing the stories osteopaths tell colleagues about the GOsC, which frame how they interpret and react to complying with the OPS. We recommend that the GOsC continue engaging and improving relations with the osteopathy profession in this way.

4. While the GOsC has a statutory duty to protect the public, and legislation restricts the GOsC's discretion about whether to formally investigate complaints, **the GOsC should aim to minimise the number of complaints taken to formal disciplinary investigations and FtP hearings.** The two osteopaths we interviewed who had been subject to FtP hearings seemed to emerge from the process less engaged with their profession and, reflecting research on complaints about other health professionals (Papadakis et al., 2008, Bismark et al., 2013), perhaps therefore at more risk of future complaints. Alternative mechanisms may more proactively address concerns, prevent malpractice, complaints and FtP hearings. Patients might be encouraged, in the first instance, to take less serious complaints to mediation (for example, using the Institute of Osteopathy's mediation service). Peer discussion reviews between professionals may prevent issues from developing into malpractice and complaints subject to FtP hearings.

5. **The GOsC might consider introducing a risk-based 'right touch' approach to osteopathic regulation using the language of 'red flags' and 'yellow cards'.** Serious concerns about osteopaths' practice or professionalism, which raise 'red flags', need to be reported to and formally investigated by the GOsC, and, if substantiated, subject to FtP hearings. Less serious concerns, which raise 'yellow cards', may be better addressed by professionals in 'formative spaces', such as the peer discussion review process, or through mediation between patients and osteopaths. To adopt this approach the GOsC needs to define 'serious' (red flags) and 'less serious' (yellow cards) issues and clearly communicate to osteopaths when they need to report concerns.

6. **The GOsC must support and encourage more reflective discussions of practice, learning and sharing between osteopaths**, whether between individuals or in groups. These are mechanisms osteopaths believed are effective for addressing minor malpractice, helping osteopaths generally improve the standard of their practice, and fuelling professional engagement. This is particularly important as many osteopaths practice in isolation and have few such opportunities.

7. **Our research supports the GOsC proposals for a formative approach to CPD and peer discussion review demonstrating assurance of continuing FtP**.
    - Our findings suggest that **osteopaths must be allowed to choose their peer reviewer** so that they are more be able to openly discuss their practice during peer discussion reviews.
    - Formalising the recording and reporting of peer review discussions may undermine osteopaths' willingness to openly discuss and address problems. The detailed **content of peer discussion reviews should therefore remain confidential, unless serious problems are raised**. **Recording and reporting might be limited** to when the process took place, who was involved, confirming an appropriate structure of topics was discussed and/or providing an overview of the discussion (for the GOsC to specify after consultation with the osteopathy profession while reflecting on patient feedback and clinical audit data), developmental actions for the osteopath to take forward, and that no serious concerns ('red flags') were raised. The **record of peer discussion reviews should be agreed between osteopaths and their peer reviewer before it is reported to the GOsC.**
    - The GOsC should support **training for peer discussion reviewers**, particularly around challenging conversations to help osteopaths address difficult issues.
    - We recommend that **peer discussion reviews take place annually**, rather than every three years as the GOsC currently propose, **with evidence of annual peer discussion reviews submitted every three years**. This would also encourage osteopaths to think of peer discussion review as a more developmental professional process rather than associated with the submission of paperwork to renew their professional registration.

1. Introduction and research background

This report describes and discusses an independent research project, commissioned and funded by the General Osteopathic Council (GOsC) and conducted by a team of academics from the University of Warwick, University of Nottingham, University of Melbourne/University of Oxford and the British School of Osteopathy, which examined osteopaths' perceptions, experiences and reactions to osteopathic regulation, compliance with Osteopathic Practice Standards (OPS) and their interrelationship with osteopathic professionalism in practice.

In June 2013, the GOsC invited research proposals to investigate the effectiveness of osteopathic regulatory activities and other factors encouraging and inhibiting osteopaths' compliance with the OPS and, consequently, what regulatory activities could support and influence osteopaths to practise in accordance with these standards. The project was intended to establish evidence to better enable the GOsC to target future regulatory activities that more effectively and efficiently support and influence GOsC registrants to comply with the OPS and thus support the provision of safe and high quality care to osteopathy patients. The three broad questions the GOsC asked where:

- What regulatory activities best support osteopaths to be able to deliver care and to practice in accordance with the OPS?
- What factors inhibit osteopaths from practising in accordance with OPS?
- What factors encourage osteopaths to practice in accordance with OPS?

In our proposal, the research team noted much public and academic interest in professional regulation, linked to 'the audit explosion' (Power, 1997) and 'transparency' in public, professional and corporate life. Regulatory transparency against standards may expose inadequate professional regulation, poor performance, and produce visible improvements in health care (Hood and Heald, 2006). Yet professional regulation can also produce side-effects that are less easily detectable or measurable (Hood, 2006), which, while giving the impression of

accountability, neither reflect nor improve professional care in practice (Hood, 2006, McGivern and Ferlie, 2007, McGivern and Fischer, 2012, Waring, 2009).

Indeed, in the aftermath of the Mid-Staffordshire NHS Trust scandal and Francis Report (2013)[1], there was public concern about a model of regulation and compliance premised on 'tick box' forms of regulation. As such, there have been growing calls for regulators to get closer to clinical practice and develop forms of regulation that promote professionalism and compliance with standards *in practice*, rather than simply policing behaviour. Effective regulation requires a closer analysis of the often complex and ambiguous nature of regulation in practice. How regulation is perceived, enacted and affects those it aims to regulate has a strong bearing on whether it will achieve its aims.

Even in a long-established and regulated professions, such as medicine, with a developed evidence-base, malpractice is often difficult for regulators to detect and substantiate in practice (Smith, 2004). Osteopathy is an emerging profession, with a complex, judgement-based and relational practice, and nascent evidence-based and standards. This makes regulating professionals against standards more complicated still. So how do osteopaths perceive these standards given the lack of robust evidence underpinning their practices; how to they judge whether their own and colleagues' practices comply with these standards and what judgements do they make in practice when deciding to comply, or not, with GOsC standards? The Shipman Inquiry (Smith, 2004) suggested that singlehanded GPs were more likely to engage in (or slip into) malpractice than those working collectively. We note that osteopaths, like psychotherapists and counsellors, often work in isolation in private practice, so how does this affect good or poor practice?

Research by the Solicitors Regulation Authority (2011) highlighted 11 dimensions for assessing attitudes towards regulatory compliance. Research by the General Medical Council (Scraggs, 2012), CHRE (Quick, 2011) and on the regulation of social work

[1] http://www.midstaffspublicinquiry.com/

(Munro, 2011, Meyeral, 2011) also highlight a number of factors that may support or inhibit professional regulatory compliance. These studies provide frameworks that explain how professionals react to regulation, often assuming that they do so in a rational way. However reaction to regulation may also be affected by non-rational factors too (e.g. anxiety, stories about regulation) and the wider regulatory contexts, beyond the control of regulators. Building on our previous research on regulatory transparency in medicine, psychotherapy and counselling (McGivern et al, 2009; 2010; 2012), patient quality and safety (Waring, 2007) and risk regulation in mental health (Fischer, 2012, Fischer and Ferlie, 2013), we suggested that creating 'formative spaces' within regulatory systems, in which professionals feel safe to openly discuss and address problems they might be facing in their practice, could be an important part of effective regulation and assuring patient safety and quality of care.

Effective regulation, we suggest, requires close analysis of the often complex and ambiguous nature of regulation in practice, using interview-based research methods, to understand how and why regulation works at micro-level, while also attending to the way that macro-level regulatory and policy contexts frame and affect regulation. To answer the GOsC's research questions, we posited wider questions:

- How do Osteopaths understand OPS and judge whether their own practice, and that of their colleagues, complies with these standards?
- Which osteopathic regulatory activities support or hinder osteopathic practice, patient quality and safety?
- Which standards are more or less difficult to comply with, and if so why?
- How do patients and members of the public judge the effectiveness and usefulness of osteopathic treatment and whether it complies with standards?
- How do osteopaths, the public and patients judge the effectiveness of osteopathic regulatory activities and standards?
- Are there any variations in respondents' views, and if so, what accounts for such variations?

- How do wider educational, organisational and regulatory activities affect compliance with standards and effective osteopathic practice?
- How can the GOsC evaluate and demonstrate the effectiveness of its regulatory activities on an on-going basis?

In the following sections of the report, we explain the research methods used to conduct this research, including semi-structured interviews with 55 people involved in or affected by osteopathic regulation (or health professional regulation more generally), including 37 osteopaths. We also ran an online survey of osteopaths on the GOsC register, which over 800 osteopaths completed, equating to a 17% response rate from the overall population of registered UK osteopaths. We explain how we analysed interview and survey data.

We then present and discuss empirical data relating to:

- Perceptions and experiences of osteopathic professional identity, practice, and evidence base to explain who and what the GOsC is regulating;

- Perceptions and experiences of the OPS, the GOsC, generic health care regulation and Fitness to Practise (FtP) hearings, showing how osteopaths perceive and experience osteopathic regulation and standards;

- How osteopaths deal with problems, near misses and complaints in practice, in order to understand the extent to which formal regulation affects practice, how informal professional practices regulate professionals and any processes which might be drawn into the way the GOsC regulates osteopaths;

- We then discuss osteopaths view about whether and how creating 'formative spaces' in 'peer discussion review' might strengthen osteopathic professionalism and regulation;

- Finally, we summarise our findings and discuss their implications for osteopathic regulation, which broadly support the GOsC proposals for CPD providing assurance of continuing FtP and informal 'peer discussion review'.

In Appendix 1 to this report, we review literature and evidence about the osteopathic profession, osteopathic practice and osteopathic regulation, highlighting the nascent nature of the osteopathy profession, the complexity of osteopathic practice and professionalism and limited evidence relating to the risks or efficacy of osteopathy. We also describe the development of osteopathic regulation in the UK, including the development of the OPS, a pilot osteopathic 'revalidation' scheme, and more recently proposals for a more formative and developmental approach to 'CPD providing assurance of continuing FtP', involving 'peer discussion review'.

In Appendix 2, we review literature about professions, health professional regulation, revalidation, and continuing FtP more broadly, which provide more background to this research project and ideas that framed our thinking. We note a tension between professions' pursuit of professional self-regulation and autonomy and the imposition of external transparency and statutory regulation. We provide detail about the development of wider health care regulatory policy affecting osteopathic regulation. We also discuss health professional regulation more conceptually and theoretically, including risk-based regulation and what the Professional Standards Authority describe as 'right touch regulation' (PSA, 2010, PSA, 2012), which enabled the GOsC to develop its proposals for 'CPD providing assurance of continuing FtP'.

Appendix 3 contains our survey questionnaire and Appendix 4 contains the survey results.

2. Research Methods

In this section we explain the 'mixed methods' (Bryman, 2008) approach we took to conducting this research, describing our research team and project advisory board, and our methods for gathering data and analysing data.

Research Team

The research was conducted by a team of university-based social science researchers, containing members with previous experience of conducting qualitative research on health professional regulation (Gerry McGivern, Justin Waring, Michael Fischer, Zoey Spendlove), a practising osteopath based in an Osteopathic Education Institution (OEI - the British School of Osteopathy) with experience of researching osteopathic practice (Oliver Thomson), and a University-based quantitative researcher, with experience of designing and analysing on-line surveys (Tomas Palaima). Three members of the team had clinical backgrounds; Oliver Thomson (an Osteopath); Michael Fischer (a psychotherapist); and Zoey Spendlove (a midwife), so the team contained a mix of 'insiders', with inside knowledge and experience of clinical practice and regulation as participants, and 'outsiders' providing an external perspective.

Research Project Advisory Board

The project team was supported and guided by a Research Project Advisory Board, containing representatives from the GOsC, practising osteopaths, members of other health professional regulatory bodies (the Professional Standards Authority and Health and Care Professions Council), who provided a range of expertise in osteopathy and health professional regulation. The project advisory board was especially informative for helping to design and configure the study, including methods of sampling and selection; for reviewing and 'sense checking' early findings

and interpretations; and for providing comments about overall study findings and recommendation. We would like to thank Douglas Bilton; Fiona Browne; Michael Guthrie; Brenda Mullinger; Haidar Ramadan; Julie Stone; and Steve Vogel for attending advisory board meetings and providing useful and constructive comments on our emerging research.

Research Ethical Approval

We received ethical approval for this research project from the University of Warwick Humanities and Social Sciences Research Ethics Committee (Reference: 40/13-14; Info-Ed Reference: 38605; Title: Exploring and Explaining the Dynamics of Osteopathic Regulation, Professionalism and Compliance with Standard Practice) on 7th February 2014 at which point we were able to begin arranging field interviews.

Background research: Literature reviews and documentary analysis

The research was initially framed by the GOsC tender document, outlining the GOsC's aims for project, and by the research team's consequent research proposal. We conducted two narrative literature reviews (Bryman, 2008) relating to, first, the osteopathy profession, its practice and regulation (see Appendix 1) and, second, professionalism, health professional regulation, revalidation and continuing FtP more broadly (see appendix 2). Together, these reviews helped the research team better understand and situate the research in relevant professional and regulatory contexts, while allowing for inductive themes to emerge from data. In common with usual social science review procedures, the reviews were carried out through systematic searches of various databases (e.g. EMBASE, Google Scholar) and through searching prominent policies, texts and papers in the area of health care regulation. Further guidance was provided by the Research Advisory Board and the specialist knowledge of the research team.

We also analysed documents relating to osteopathic regulation, most of which was available on the GOsC website (http://www.osteopathy.org.uk/), including reports produced by KPMG reports (KPMG, 2012a, KPMG, 2012b) on the GOsC revalidation pilot.

Semi-structured qualitative interviews

Based on the literature reviews and documentary analysis, we developed a set of interview questions for practising osteopaths and representatives of OEIs. This provided a consistent guide and structure for semi-structured interviews (Kvale and Brinkmann, 2009, Bryman, 2008), enabling us to compare data across interviews, while allowing the interviewers some flexibility to explore interesting issues emerging in interviews. The table below shows the guide and questions we used for conducting interviews.

Interview guide

Pre-briefing statement guide

I am [name], an [role: researcher/academic) from [X institution], and working as part of a research team exploring osteopaths views and experiences of professional standards and regulation for a research project funded by the GOsC, which aims to improve the effectiveness of osteopathic regulation. Information about the research is detailed in the information sheet you will have read. Do you have any questions about the project?

Thanks for agreeing to be interviewed. I want to emphasise that everything we discuss will remain confidential within the research team. While the project is funded by GOsC, the project team is independent of GOsC, and GOsC will not have direct access to interview data. If we report on anything you say it will be fully anonymised, so that no one could trace comments back to you.

There are no right or wrong answers to our questions; we are interested in your personal views, experiences and perceptions. So please be as honest and open as you can be, as this will help us explain regulation as it actually as experienced and practiced in practice, and accordingly inform regulatory policy. Is that all clear and ok? Do you have any further questions before we begin the interview?

Opening questions

You filled in the biographical form, so you… [use as a prompt for an introductory narrative/conversation about their background as an Osteopath].

1. What led you to become an osteopath? [And what have been the biggest influences on you as an osteopath?]
2. Why did you choose to take part in the study?

Professional (osteopathic) views

3. How would you describe osteopathy as a practice?
4. What does being an osteopath mean to you?
5. What is your view about the use of research and evidence in osteopathy?

- [Prompt, if appropriate, where do you access research/ evidence about osteopathy, e.g. Journals, GOsC or NCOR websites, via colleagues?]

Standards/regulation in osteopathic practice

6. Can you briefly take me through your last session with an osteopathic patient? [whilst maintaining patient confidentiality]

- Prompt: Can you describe any points during the session when you were consciously thinking about osteopathic standards or regulation? What aspects of aspects of practice did they relate to? Why did you think about standards then? If interviewee didn't think of regulation or standards, why not, and what were the main drivers of your actions during session?

7. Can you tell me about any times when you worried about any aspect of your osteopathic practice, had any actual problems or near misses (what, when and why)? How did osteopathic regulations and standards affect your

practice/thinking at these times? How did you address this concern/issue in practice (e.g. reading up, speaking to colleagues)?

8. What, for you, are the most effective ways of ensuring safe and effective osteopathic practice?

Attitudes towards standards/regulation

9. When I say 'regulation' what comes into your mind? (Follow-up probing questions, including wider influences, e.g. the media, politicians, law on regulation is perceived).
10. What is your perception/experience of the GOsC?
11. How do you engage with osteopathic regulation, standards and maintain your status as a registered osteopath?
12. How do you judge whether your behaviour and practice meets osteopathic standards?
13. Can you describe any ways in which you find any osteopathic standards/regulation useful? (Which ones and why? Any examples in recent clinical practice?

- Prompt whether and to what extent it triggers reflection, discussion with colleagues? For the osteopathy profession? Are any osteopathic standards particularly important and/or helpful? [To you, osteopaths, and patients]?

14. Can you describe any ways in which you find any osteopathic standards/regulation problematic? Which and why?
15. How would you react if a patient made a complaint to you/GOsC about unprofessional or poor osteopathic practice?
16. Have you ever suspected a colleagues' practice to fall short of osteopathic standards? [What did you do/would you do? How would you judge whether colleagues' behaviour and practice is meeting osteopathic standards?]
17. Did you take part in the revalidation pilot? If so, what was your experience of it? How might the process be improved? [The Prompt discussion of 'formative spaces']
18. In your view what would constitute 'good' regulation of the osteopathic

profession?

19. Is there anything else you would like to add?

In accordance with good research practice and the terms of our research ethical approval, interviews were conducted in confidence and interview data was only seen by members of the research team; the GOsC did not have access to raw unprocessed and un-anonymised interview (or survey) data.

We devised a sampling framework (which we have not included to maintain the anonymity of interviewees), to guide our selection of interviews, which included a range of osteopaths (representing the different constituencies within the profession), representatives of OEIs, patients, people involved in FtP in GOsC and other health professional regulators. Information about the research was also published in two issues of *The Osteopath (Feb/March 2014 p10; June/July, p6).* Some osteopaths volunteered to be interviewed. We also approached other osteopaths and specific individuals who had particular experiences, for example osteopaths who had been subject to FtP Hearings or represented Osteopathic groups or OEIs.

In total, we conducted 55 interviews, in person (n= 27) and by telephone (n =28) with the choice of telephone or face-to-face interview driven by logistical considerations (e.g. by telephone where prohibitive travel time was necessary to conduct an interview in person). Four members of the research team conducted these interviews (McGivern (n=29); Spendlove (n=14); Thomson (n=11); Fischer (n=1)), minimising the possibility of 'interviewer effects'; interviewees reacting to one interviewer a particular way. Interviewers took an 'active interviewing' (Holstein and Gubrium, 1999) approach, engaging in deep listening and reflective questioning. On average, interviews lasted about one hour, but ranged in duration from 15 minutes to 2 hours 15 minutes. The majority of interviews were conducted between March and July 2014, with two final interviews in September and October 2014.

Interviewees were asked to complete a sheet providing written informed consent to being interviewed and having their data analysed, and another sheet containing

demographic information for osteopaths to indicate, which enabled the research team to analyse interview data by demographic characteristics. Telephone interviewees were sent the sheets and asked to complete them in advance on interviews. Interviews were audio recorded and transcribed for analysis.

Interviewees included:

- 37 osteopaths, with a range of osteopathic approaches, having graduated from different OEIs.
- 8 interviews representing OEIs; 4 representing approaches/schools of osteopathy; a chiropractor based at a school of chiropractic. We were unable to interview representatives of some OEIs which did not respond to our requests for interview.
- Representatives of key osteopathic organisations, including the British Osteopathic Association (Institute of Osteopathy), Osteopathic Alliance, NCOR and regional osteopathic groups.
- 2 osteopaths who had been through GOsC FtP hearings
- 3 patient representatives (one who had made a complaint to the GOsC about an osteopath)
- 4 people working for GOsC in various roles
- 5 people in FtP roles in other health professional regulators
- A news producer for a national media organisation
- A representative from the Law Commission involved in drafting a new health professional regulation bill
- A politician with an interest in health professional regulation and associated legislation
- Our sample included 27 female and 28 male interviewees.

Demographic sampling of osteopaths

Of the 37 osteopaths we interviewed:

- 19 were men and 18 women; which broadly reflects with wider population of osteopaths (including as indicated by our survey data)
- 12 were based in the South East (including Oxfordshire); 8 in London; 5 in the South West; 3 in the Midlands; 3 in the North East (in Yorkshire); 2 in the North West; 2 in Scotland; 1 in East Anglia; 1 in Wales. These are broadly in line with the wider populations in different regions, as indicated by our survey data.
- 2 had been qualified for under 5 years, 3 for 5-14 years, 18 for 15-24 years and 14 for 25 or more years, so interviewees' accounts over-represent the views and experiences of longer qualified osteopaths, compared to survey data.
- 9 worked in solo practice (although 3 of these also had roles in OEIs) and 28 in group practices (whereas in our survey 45% of osteopaths reported working alone and 55% working with others). So osteopaths working alone are under-represented and those working with others are over-represented in our sample of interviewees, as compared with the wider population of osteopaths as indicated by our survey data and previous research by KPMG (2012b) about 'how osteopaths practise'.
- 13 of the people we interviewed trained at the British School of Osteopathy, 9 at the British College of Osteopathic Medicine, 5 at the College of Osteopaths, 5 at the European School of Osteopathy, 2 at Oxford Brookes University, 2 at the London School of Osteopathy, and 1 at the London College of Osteopathic Medicine. This is also broadly in line with demographic data from our survey respondents.

In sum, we believe the sample of interviewees broadly reflect the population of UK osteopaths overall, although we acknowledge that recently qualified osteopaths and those practising alone are relatively under-represented. Furthermore several interviewees represented OEIs or osteopathic groups. We may, therefore, have

interviewed relatively few osteopaths who are disengaged or isolated from the GOsC or the osteopathy profession more generally and less likely to hear about or volunteer to be interviewed for this research.

This is a recognised issue in all social science research. Hard to reach groups, or those who do not want to take part in research are difficult to recruit, while often these are groups integral to the research focus (Bryman, 2008). In the case of professional regulation, it is those most out of reach from regulatory practices that are, perhaps, least likely to take part. However we cannot compel people to take part in the research and if we did it would change the quality of our findings.

Analysing interview data

We initially conducted a 'framework analysis' (Richie and Spencer, 1994) of osteopaths' narrative responses to interview questions, coding them in an excel table using 'in vivo' codes inducted from data. This table enabled us to compare themes across interviews and to assess the extent to which particular views could be generalised (Miles and Huberman, 1994). The codes in the table reflected survey questions, which included:

- how interviewees became an osteopath;
- description of osteopath as a practice;
- what being an osteopath means;
- view of research/evidence in osteopathy;
- anonymised account of last session with a patient;
- account of times when worried about own practice;
- view of how to ensure safe and effective practice;
- what comes to mind when interviewees think of 'regulation';
- perceptions and experiences of GOsC;
- how osteopaths engage with osteopathic regulation and standards;

- how osteopaths judge whether they are meeting osteopathic standards;
- useful osteopathic standards;
- problematic osteopathic standards;
- how osteopaths react if they received a complaint;
- how osteopaths act if they suspected a colleague of poor practice;
- experience of revalidation pilot;
- views on peer review and formative spaces;
- anything else of interest.

We have not displayed this table in the report to preserve the anonymity of interviewees.

We note that analysis of data about 'how to ensure safe and effective practice' enabled us to analyse the extent to which osteopaths believed CPD activities would be a useful way to assure continuing FtP. Our analysis of anonymised account of osteopaths last sessions with a patient' enabled us to analyse the extent to which osteopaths' practice was consciously or unconsciously affected by OPS.

Having established the extent to which particular views were generalizable, we analysed interview transcripts in more depth, using methods for qualitative analysis (Corbin and Strauss, 2008, Miles and Huberman, 1994) and 'thematic analysis' (Boyatzis, 1998). We then used anonymised narrative interview extracts to illustrate views and experiences, which we present in this report.

Survey

We conducted an online survey of all 4900 osteopaths on the GOsC register (at the time of the survey: July-Sept 2014), asking questions emerging from the research questions the GOsC set us, the review of literature and the findings of qualitative interviews. Questions drew upon questions from previous research, as far as

possible to enable comparison of our findings with previous research. Questions 15, 16, 17, 18, 23, 24, 55, 57, 61 were based on questions from the 2012 GOsC opinion survey[2]. Questions 7, 8, 10, 11 were based upon previous research on GPs' attitudes towards 'evidence' in medicine (McColl et al., 1998). We drew on previous survey-based research relating to doctors' and nurses' attitudes towards whistleblowing, questions 46, 57, 62 (Firth-Cozens et al., 2003) and questions 59 and 62 (Moore and McAuliffe, 2009). Questions 51 based upon previous research relating to 'psychological safety' (Edmondson, 1999).

We then piloted the questions with 10 osteopaths, and changed questions in response to feedback, for example rewording questions so that they made more sense to osteopaths, removing questions osteopaths considered unnecessary or duplicated by other questions. Our final survey questions are show in Appendix 3.

Then, using Qualtrics software licenced to Warwick Business School, we ran an online survey over a six week period (22nd July to 7th Sept 2014). The relatively long time period the survey was open reflected participants' potential limited availability over the summer holiday period.

Recruitment of participants involved sending osteopaths on the GOsC register emails (or letters for those for whom GOsC did not have an email address) directing them to the online survey. GOsC registrants then received several further email reminders to complete the survey throughout the period.

We received 809 responses to the survey, which equates to a response rate of 17%.

The demographics of survey respondents were broadly in line with the findings of the KPMG (2012b) research, which were:

- 51% of survey respondents were male, 44% female, 6% preferred not so say.

[2] http://www.osteopathy.org.uk/about/our-work/consultations-events/Osteopaths-opinion-survey-2012/

- 7% of survey respondents said they were 30 years of age or less, 55% were 31-50 years of age, 36% we 51-70 years old, 1% were over 70 years old.

- The majority of survey respondents were from 'white British' (71%) or 'other white; (10%) background. 1% were 'Indian', 1% 'mixed white and Asian', 1% 'other mixed' and 1% 'other ethnic' background. 12% of respondents preferred not to provide information about their ethnicity.

- 16% of survey respondents said they had been qualified as an osteopath for less than 5 years, 27% for 5-14 years, 27% for 15 to 24 years, and 30% for more than 25 years.

- 47% of survey respondents graduated from the British School of Osteopathy; 14% from the European School of Osteopathy; 13% from the British College of Osteopathic Medicine; 7% from the College of Osteopaths; 6% from Oxford Brookes University; 5% from the London School of Osteopathy; 2% from the Surrey Institute; 1% from Leeds Metropolitan University; 0.5% from the London College of Osteopathic Medicine; and .025% from Swansea University.

- 31% of survey respondents practised in the South East; 23% in London; 14% in the South West; 9% in the Midlands; 6% in East Anglia; 5% in the North West; 4% in Scotland; 3% in the North East; 3% in Wales; and 0.5% in Northern Ireland.

- 45% of osteopaths responding to the survey practised alone; 55% with others.

- 61% of osteopaths responding to the survey worked full-time; 39% part-time.

- 97% of osteopaths responding to the survey reported working in independent practice; 16% in the Education sector; 7% in the NHS and 3% in the research sector.

- 7% of survey respondents reported having had a complaint made against them to the GOsC; 2% a legal claim against them; and 14% a complaint which did not go to the GOsC.

We acknowledge that osteopaths who ignored or did not receive emails from the GOsC or had limited internet access would have been less able to participate in the survey.

Survey analysis

We analysed the numbers and percentage of responses to each question by category (for most questions strongly agree, agree, neither, disagree, strongly disagree - see Appendix 3 – Survey results). For simplicity, we summed the strongly agree and agree responses to produce an overall percentage agreeing, and strongly disagree and disagree to produce the overall percentage disagreeing, which we present in this report. In places, we also present the mean response to questions on a scale of 1-5 where 1 represents strongly disagree, 3 neither agree nor disagree and 5 strongly agree.

We conducted T-tests to see if variations in results by demographic criteria were statistically significant (Field, 2009).

In order to identify the dimensionality of the constructs measured and reduce the number of variables, exploratory factor analysis (a principal components method) was employed. As the constructs of the study originate from social sciences, they might be correlated. Consequently, direct oblimin rotation was used to allow correlations between factors (Field, 2009).

Firstly, all survey questions, ranging from Q1 through to Q52.5_4, were included in factor analysis. Secondly, individual items and items with factor loadings bellow .5

were removed. Thirdly, factor analysis was repeated without items removed in stage two (Netemeyer et al., 2003). Finally, exploratory factor analysis demonstrated that ten factors exist, which we list below:

1. *Factor 1: 'Favouring formal peer review'*

Factor 1 linked responses to the following questions:

- 'I would be able to bring up problems and tough issues during a peer review if it involved: Formal discussion of my practice in an osteopathic group accredited for the purposes of peer review.'
- 'I would be able to bring up problems and tough issues during a peer review if involved: Formal observation of my practice by an accredited peer reviewer.'
- 'Peer review would produce fair outcomes if it was conducted in formal discussion with an accredited peer reviewer: appointed by the GOsC.'
- 'Peer review would produce fair outcomes if it involved: Formal observation of my practice by an accredited peer reviewer.'
- 'Peer review would produce fair outcomes if it involved: Formal discussion of my practice in an osteopathic group accredited for the purposes of peer review.'
- 'I would be able to bring up problems and tough issues during a peer review conducted in formal discussion with an accredited peer reviewer: Appointed by the GOsC.'
- 'Peer review would have a positive effect on how I practise as an osteopath if it involved: Formal observation of my practice by an accredited peer reviewer.'
- 'Peer review would produce fair outcomes, as part of a GOsC process to provide assurance of continuing FtP.'
- 'Peer review would produce fair outcomes if it was conducted in formal discussion with an osteopath accredited as a peer reviewer by: An established advances practice group…'

- ‘Peer review would have a positive effect on how I practise as an osteopath if it involved: Formal discussion of my practice in an osteopathic group accredited for the purpose of peer review.’
- ‘Peer review would have a positive effect on how I practise as an osteopath if peer review was conducted in formal discussion with an accredited peer reviewer: Appointed by the GOsC.’
- ‘I would be able to bring up problems and tough issues during a peer review, as part of the GOsC process to provide assurance of continuing FtP.’
- ‘Peer review would produce fair outcomes if it was conducted in formal discussion with an osteopath accredited as a peer reviewer by: An established OEI.’
- ‘I would be able to bring up problems and tough issues during a peer review conducted in formal discussion with an osteopath accredited as a peer reviewer by: An established advanced practice group…’

2. *Factor 2: ‘Favouring informal peer review’*

Factor 2 linked responses to the following questions:

- ‘Peer review would have a positive effect on how I practise as an osteopath if it involved: Informal discussion of my practice in an osteopathic group.’
- ‘I would be able to bring up problems and tough issues during a peer review if it involved: Informal discussion of my practice in an osteopathic group.’
- ‘Peer review would produce fair outcomes if it involved: Informal discussion of my practice in an osteopathic group.’
- ‘Peer review, involving informal discussion with another osteopath would produce fair outcomes.’
- ‘I would be able to bring up problems and tough issues during a peer review involving informal discussion of my practice with another osteopath.’
- ‘Peer review, involving informal discussion of my practice with another osteopath, would have a positive effect on how I practise as an osteopath.’

- ‘Peer review would have a positive effect on how I practise as an osteopath, as part of a GOsC process to provide assurance of continuing FtP.’

3. *Factor 3: ‘Feeling compliant with standards’*

Factor 3 linked responses to the 5 following questions:

- ‘I have a clear sense of whether I am complying with the OPS while practising as an osteopath.’
- ‘What I do as an osteopath always fully complies with all the OPS.’
- ‘I find it difficult to demonstrate that what I do as an osteopath complies with the OPS.’
- ‘I am familiar with the current OPS.’
- ‘Complying with the OPS restricts my ability to provide care that I believe would benefit patients.’

4. *Factor 4: ‘Pro-evidence-based practice’*

Factor 4 linked responses to the 5 following questions:

- ‘Practising evidence-based osteopathy improves patient care.’
- ‘Evidence-based practice is a welcome development in osteopathy.’
- ‘Research findings are useful in my day-to-day management of patients.’
- ‘An emphasis on evidence-based practice will undermine important aspects of osteopathic practice.’
- ‘Every osteopath has a duty to keep up-to-date with research and evidence about osteopathic practice.’

5. *Factor 5: ‘Pro-GOsC’*

Factor 5 linked responses to the 6 following questions:

- ‘The GOsC communicates well with osteopaths.’
- ‘The GOsC consults well with osteopaths.’
- ‘I am confident that osteopaths are well regulated by the GOsC.’
- ‘The GOsC are improving the status of the osteopathic profession.’
- ‘The GOsC registration fees are reasonable.’
- ‘Regulation has had a positive effect on how I practise as an osteopath.’

6. *Factor 6: ‘Fear-based compliance with standards’*

Factor 6 linked responses to the 3 following question:

- ‘I comply with the OPS to avoid getting into trouble with the GOsC.’
- ‘I comply with the OPS to protect myself against being sued by a patient.’
- ‘My perceptions of the GOsC are primarily based’ on ‘my fear about what the GOsC could do to me or my osteopathic practice’.

7. *Factor 7: ‘Osteopathic distinctiveness’*

Factor 7 linked responses to the 3 following questions:

- ‘I believe osteopathic practice is distinctive from other manual therapies…’
- ‘I believe osteopathy is a unique health care profession.’
- ‘I see myself as an osteopath first, and then as a health care professional.’

8. *Factor 8: ‘Experiential perceptions of the GOsC’*

Factor 8 linked 2 responses to the question exploring what ‘My perceptions of the GOsC are primarily based on’:

- ‘My experiences of the GOsC.’

- ‘The GOsC’s communication.’

9. Factor 9: ‘Clarity about reporting colleagues’ poor practice’

Factor 9 linked responses to the 3 questions:

- ‘I am clear about when to report another osteopath to the GOsC.’
- ‘I am clear about how to report another osteopath to the GOsC.’
- ‘I would always report another osteopath to the GOsC for serious malpractice.’

10. Factor 10 ‘Narrative perceptions of the GOsC’

Factor 10 linked 2 responses to the question exploring what ‘My perceptions of the GOsC are primarily base on’:

- ‘What I hear from professional colleagues.’
- ‘What I hear about regulation in the news.’

We discuss these factors and related survey responses, overall and by demographic criteria, throughout the report.

Summary

In summary, after receiving research ethical approval, our research team carried out a ‘mixed methods’ study, involving semi-structured interviews, based upon questions informed by the aims set out in the GOsC project tender document and background literature reviews, with 55 people; these included 37 osteopaths, broadly representing the wider population of osteopaths in the UK. We analysed interview data using methods for qualitative data analysis, using narrative extracts from interviews to illustrate findings. We then conducted an online survey of all

4900 GOsC registered osteopaths in the UK (at the time if the survey) which elicited a 17% response rate. We analysed survey data, conducting T-tests for statistical differences between demographic criteria and exploratory factor analysis, looking for aggregate factors comprised of other factors linked to responses to survey questions. Our analysis indicated a number of Factors, which we discuss below.

3. Osteopathic professional identity, practice and evidence base

Introduction

In this section we examine how osteopaths described osteopathy as a practice, their professional osteopathic identities and perceived osteopathic evidence.

Descriptions of osteopathy

As discussed in Appendix 1, while there are many descriptions of osteopath there is no agreed definition of osteopathy as a practice. Osteopaths described their profession as a "broad church" (4.2O), involving a range of approaches towards and interpretations of osteopathy, with different opinions about how similar or distinct osteopathy was from other manual therapies, such as physiotherapy or chiropractic. As one osteopath we interviewed noted:

> *"There are different ways of approaching things… Some osteopaths are down at the almost 'healing' end of the spectrum in terms of an esoteric approach to patients... cranial and biodynamic and that kind of stuff, whereas there are plenty of osteopaths… who are very structural… One of our colleagues yesterday was saying how he was shocked to hear somebody say… there is no real difference these days between osteopathy and chiropractic and physiotherapy, and he felt that was almost sacrilege and blasphemous… I think there are as many differences within the professions as between them at times. It depends who you are seeing and what the approach is. I have seen chiropractors and physios [physiotherapists] who have what I would consider to be a fairly osteopathic approach… and I have seen lots of osteopaths who, you think, it doesn't sound like osteopathy." (4.23G)*

Another osteopath commented:

> *"I tend to be very flippant when I get asked about the difference between osteopathy and chiropractic, I say, the difference is spelling! … Having said that, chiropractors do have a slightly different philosophy and a slightly different model for the reason they are doing what they are doing. They tend to use more direct thrusts… to focus more spinally than peripherally… tend to have shorter … and more frequent treatment times… Your basic physiotherapy degree … qualifies you to enter the NHS…. I see their [physiotherapists] role more as integrating with the NHS." (5.6G1)*

A third line of thinking was that there was something distinctive to osteopathy, compared with other manual therapies, despite the broad range of osteopathic approaches, although it was difficult to articulate:

> *"There is something important in what we do and it is somehow a little bit different to what the physios and the chiropractors and the other manual therapists do. But I don't think I can put my finger on what that difference is. I think we are a fairly disparate bunch… an unorthodox group as well. There seems to be a lot of different ideas and quite a lot of fluffy ideas. And with this I think it has attracted people because... because of some of those esoteric variables… There is a broad range of opinion within what we do from the extreme biomechanical operators to the kind of quasi-religious quasi-mythical practitioners at the other end… almost medicine without the kind of doctor, from a very broad medical type of approach, to something that is much more akin to the more esoteric alternative therapies." (3.24O)*

Thus osteopaths appeared to be both diverse and distinct as a health care profession, meaning that OPS needed to allow for the diversity of osteopathic approaches while setting out core standards important for all osteopaths, which creates some tensions around the broad ways in which standards could be interpreted.

Osteopathic practice is primarily anchored in particular aspects of work, with associated mental models, ideas and aspects of professional identity. This included a concern with holism, adjusting the health and 'arrangements' of the whole body in relation to the environment, concerned with health more broadly rather than illness. Osteopaths describe a 'cultivated subjectivity' in which interpersonal relations play a significant role, using a physical and 'hands on' medium of assessment and treatment. Osteopaths also often strongly valued 'osteopathic philosophy', which extended beyond mechanistic or 'manualised' approaches to treatment, to encompass a range of meanings. The implication is that where standards or directives may be seen as neglecting these wider meanings, as inadequate (or even misdirected), potentially missing key aspects of osteopathic practice.

One osteopath we interviewed commented:

> "O*steopathy is a part of what medicine should have become: namely, paying attention to the machinery of life and not just to illnesses and diseases… Osteopathy is concerned with the art of adjustment, and not just the body to itself, but the art of [adjusting] human beings to his environments, which is the emotional and if you like spiritual environment…Yes it is the whole thing. And we can experience that by thinking about… how the patient feels in the broadest sense… We are using ... cultivated subjectivity... instead of the modern trend of saying, we need a baseline against which we measure something. We rely entirely on our sense of perception. So the feeling is huge. It is beyond the six senses, it is remarkable….one just removes the filters… using my hands in a way so as to allow better system of vitality to pervade the organs… [using] a process of analysis at first, with a lot of different models in my mind as to what it [the cause of the patient's problem] might be and questioning what other people thought it might be… what might have happened… Feeling what is there, not at the surface but in a cybernetic loop… and trying not to have an opinion whilst it is happening because that gets in*

the way. But that is not magic; that is intuition as I would define… knowledge without recourse to inference, because I have felt it before. (04.09G)

So this osteopath describes osteopathy as holistic; concerned with understanding patient in their environment, involving diagnosis based upon emotional response, feeling, perception, and intuition about the patient's condition.

Other osteopaths similarly described the importance of feeling patients' bodies with their hands ('palpation'), as one put it:

"I have heard osteopathy described as a conversation between your body's tissues and my hands. So, my hands can be carrying on a conversation whilst our heads are engaged in a different conversation." (5.6G1)

Another osteopath similarly described osteopathy as:

"It is a patient-centred primary health care, based on manual therapy, but based on a sense of touch and it does involve some manipulation, some gentle movements of the bodies. But the great thing is it is a communication between you and a patient through touch." (04.16 Z2)

Indeed most osteopaths talked about the importance of touch and communication between the osteopath and patient. The relationship between osteopaths and their patient was also another important aspect of their practice:

"[Osteopathy] is a relationship-based intervention, so it is not simply… a manual therapy, because the basis of how we treat people is not only our manual therapy skills but also our relationship skills. It is a contract between the patient and the osteopath… ensuring… as the problem begins to get identified and begins to be dealt with… the person can… begin to take charge of it" (5.30 ZS)

Some osteopaths talked about how osteopaths enabled patients' bodies to heal themselves:

> *"I am very much into the fact that the body heals itself, so that we are promoting healing within the patient's own body… I believe that an osteopath should have a whole range of techniques and tools if they can, to be able to prompt that healing, because each patient requires something different… I don't see osteopathy as something that I impose... my technique upon the patient. I am looking for what is the key to finding what will heal that patient." (5.1Z)*

Many osteopaths believed that osteopaths provided a form of health care that was often more beneficial to patients than conventional medicine:

> *"[Osteopaths] know as much as a doctor knows… We can do something about your back pain and not point you in the direction of the favourite pharmaceutical… [Conventional] health care has gone down a route that is not necessarily for the benefit of the population." (3.21G)*

Being an osteopath was also an important part of many osteopaths' identities. An osteopath described being an osteopath as:

> *"It is a great privilege… very important to me. I am of an age when I could, technically, be retired… I would miss the work and … interactions… I am … proud of being an osteopath and I wouldn't want to be a something else. It is very important as part of my personal identity." (04.16 Z2)*

Another noted:

> *"If I won the lottery and never had to work again, I would still work as an osteopath… I am passionate about osteopathy… the philosophies and the*

patients – it is nice to make a difference. I find it is a challenging and interesting profession… I love being an osteopath." (4.23Z2)

For many osteopaths we spoke to it was important that they were helping patients. As one osteopath noted:

"It is important that I can provide a service to my community that hopefully improves people's wellbeing in my community. If somebody comes back to me and says: "You made my day better", and that might be something simple, "because I can put my shoes on or I can play with my grandchildren", then that is fine. I have done my job. It is about just making life a little bit better for people" (5.7Z2)

The 'business' aspect of osteopathy is an important additional anchor that is tied to the development of reputation and a client base that may build over time. This may be tied to practitioners' tangible sense of effectiveness and supports their identities as practitioners:

"[Osteopathy] is also a business... a livelihood, and it is financially rewarding. So there are those kinds of two strands of it being therapeutic and financial. You … have to weave those together sometimes and you make decisions about fee levels and concession fees… In the end you are building a reputation… a practice which stands or fall on its reputation. (5.30 ZS)

Osteopaths earn more money by attracting more patients. Osteopaths therefore have an interest in collectively developing the quality and reputation of the osteopathy profession, while individually competing for patients with other osteopaths, so there is a disincentive to them helping improve the quality of their local competitors' osteopathic practice.

Many osteopaths had trained as osteopaths because doing so enabled them to work independently and more flexibly than an alternative NHS career:

"It has enabled me to have a really flexible career… I have been able to work for myself. So I run my own business." (4.16G2)

The results of our survey suggested that most osteopaths believed that osteopathy was a distinct profession; 84% of osteopaths agreed 'osteopathy is a unique health care profession' (8% disagreed) and 83% of osteopaths agreed that 'osteopathic practice is distinctive from other manual therapies' (7% disagree). However, while most osteopaths (55%) agreed that 'I see myself as an osteopath first, and then as a health care professional, some (22%) disagreed, seeing themselves as more generic health care professionals.

We conducted an exploratory factor analysis of survey data, which indicated an aggregate dimension relating to 'osteopath distinctiveness' (Factor 7; mean response 3.93, where 5 indicates strongly agree and 1 strongly disagree), which comprised three factors: (i) 'I believe osteopathic practice is distinctive from other manual therapies…', (ii) 'I believe osteopathy is a unique health care profession' and (iii) 'I see myself as an osteopath first, and then as a health care professional'. We found that female osteopaths were significantly more likely (mean 4.01) than male osteopaths (mean 3.89) to perceive 'osteopathic distinctiveness' (Factor 7). There was also a significant association (0.146) between being qualified longer as an osteopath and perceiving 'osteopathic distinctiveness'.

The majority of osteopaths (55%) agreed that 'Overall, I believe that the quality of patient care provided by osteopaths in the UK is improving' (only 11% disagreed) but only 34% of osteopaths in our survey agreed that 'medical professionals (e.g. GPs, hospital consultants) I come into contact with take osteopathy seriously'. While many osteopaths had a strong sense of professional identity, some osteopaths we interviewed also noted a sense of *"insecurity" (5.14G)* and *"fear and cynicism… in the profession" (4.23G)* and that *"there is still quite a lot of insecurity in osteopathy… I don't know if all osteopaths… feel secure enough about what they do" (*4.16G2).

In sum, we note a range of approaches towards and interpretations of osteopathy, from the quasi-medical structural approach to a more esoteric form of healing. Some osteopaths argued that osteopathy was highly distinctive from other manual therapies (such as physiotherapy or chiropractic), while others believed the boundaries between these professionals and their practices were blurred.

Most osteopaths, however, took a holistic approach to osteopathy, considering patients and their clinical problems in their wider living context and osteopathy was described as patient-centred (rather disease or injury centred). Feeling and the use of osteopaths' hands (palpation) to diagnose and treat patients was important for osteopaths, as well as their subjective and intuitive sense of patients and their conditions. The relationship and communication between osteopaths and their patients was another important facet of osteopathic practice. Some osteopaths talked about osteopathy helping patients' bodies to heal themselves (rather than relying on to surgical or pharmaceutical interventions to do so).

While an holistic, patient-centeredness, relationship between patient and osteopath, 'hands on' palpation, feeling, subjectivity, and intuition are seen by osteopaths to be crucial facets of osteopathic practice, they are difficult to objectively assess against written standards, meaning that while osteopaths intuitively have a sense of whether practice meets acceptable osteopathic standards, this may be difficult to articulate.

For most osteopaths we interviewed and surveyed, being an osteopath and helping patients to feel better was an important part of their identity. However osteopathy is also a 'business' and a reputation for helping patients enables osteopaths to compete for patients with professional colleagues. Osteopaths often work flexibly and independently, outside large organisations like the NHS, which also affects the nature of osteopathic regulation, as will discuss later.

The nascent osteopathic evidence-base

We suggest that professional insecurity was, in large part and despite the recent development of the National Council for Osteopathic Research (NCOR) due to the lack of evidence underpinning the efficacy of osteopathic practice. While osteopaths were generally positive about evidence based or 'evidence-informed practice' in osteopathy, many noted the limited and nascent osteopathic evidence based. One osteopath "from an academic… scientific background" who had "done research and been published" noted:

> *"I can look at data… understand the scientific method, and I am very analytical… as an osteopath there is a lot of uncertainty… a lot of theory… blurred edges and … not a lot of hard data… When I talk to patients about research actually there is no research to support what I am doing, they are like, 'I don't give a toss… I feel better and I am happy to pay you money to feel better'. I am caught between… that dichotomy… of 'you must have evidence for everything that you do' and the fact that there isn't really the evidence…. Osteopathy [needs]… to start to publishing as many case studies [as possible and]… get kinds of groups of case studies, all indicating that there is something happening". (4.14O)*

Another osteopath commented:

> *"The osteopathic profession is supremely guilty of evidence bias. When we find a study that seems to support us we welcome it, and if we find a study that doesn't, we disparage it or dismiss it… We are in a very difficult situation where we profess to work with the framework of evidence based medicine, but there isn't really very much evidence at all… osteopathy really still, is not just a tradition but it is an oral tradition. That is how it was shared and passed on and we have got growing pains ahead of us." (5.6G1)*

Osteopaths voiced concern that 'biomedical' or 'pharmaceutical' models of research and evidence did not fit the more holistic, relational and 'hands on' nature of osteopathic practice:

> *"The typical drug pharma model doesn't work [in osteopathy] … trying to apply simplistic solutions to conditions and researching those doesn't work, because how people got their problem is incredibly different and affected by psycho-social factors.... When we practise osteopathy it is an interaction with people … not simply a few pops and clicks in a prescribed area…. There is value in them [patients] talking to the osteopath … Our current research models don't take that into account… Working from evidence is a good idea, as long as ... we are served by our experience, by what you can call empirical evidence.... The temptation is to try and boil it down to a 'if [x] is exhibiting [y] symptoms then prescribe and [z] procedure'… [Osteopathy] just doesn't work like that…. There are models outside osteopathy like… psychotherapy and homeopathy and acupuncture… We need people who really understand research outside the very traditional kind of pharma model… [Osteopaths] are getting there but we don't have a big tradition of research, certainly in Europe and the UK…. But… you can't do double blind RCTs for osteopathy… can't do easy placebo based controls if what you are doing is touching somebody... If you touch one bit of somebody effectively through their connective tissue network you have access to that whole person, effectively. And how you touch somebody… has an effect… so you can't apply medical standards." (6.6G2)*

Another osteopath similarly noted:

> *"The research models that make up the bog-standard of meta-analysis and gold standards are too restrictive for the inclusiveness of osteopathic consideration or health. There are too many variables and too many inputs for it ever to be shown. Saying that osteopaths do a technique – osteopaths do a lot more than that – and a lot of medicine is doing a technique. Researching technique … isn't osteopathy." 24.6G*

One osteopath, trained as a scientist before becoming an osteopath, commented on some osteopaths' "fear" of research; particularly that osteopaths *"could lose their livelihoods if you show that osteopathy doesn't work"*. However the osteopath noted:

> *"I am confident enough to believe that it [osteopathy] does work, from what I have seen, anecdotal… and the empirical evidence…. I am [not] going to stop doing research because it might show that what we are doing is wrong … There is that insecurity, … more mature osteopaths, if I can put it like that, sometimes have quite a fear of the scientist… fear is a lack of understanding of what the researcher is trying to achieve…. fear of the unknown." (15.4G)*

The results of our survey corroborated these findings. The majority of osteopaths responding to the survey agreed that 'evidence-based practice is a welcome development in osteopathy' (57% agreed; 18% disagreed) and that 'research findings are useful in my day-to-day management of patients' (54% agreed; 19% disagreed). Most osteopaths believed they 'have the skills to critically appraise research relevant to osteopathy' (61% agreed; 10% disagreed) and that 'every osteopath has a duty to keep up-to-date with research and evidence about osteopathic practice' (76% agreed; 6% disagreed). 28% agreed (46% disagreed) that 'evidence-based practice is of limited value in osteopathic practice because osteopathy lacks a robust scientific base'. However fewer believed that 'practising evidence-based osteopathy improves patient care' (39% agreed; 27% disagreed) and the majority of osteopaths responding to our survey (53% agreed; 23% disagreed) believed 'an emphasis on evidence-based practice will undermine important aspects of osteopathic practice.' Thus, reflecting interview data, survey results suggest that evidence based practice has both benefits and potential dangers.

From our exploratory factor analysis of survey data we found an aggregate factor for 'Pro-evidence based practice' (Factor 4; mean response 3.29, where 5 indicates strongly agree and 1 strongly disagree), comprising five factors: (i) Practising

evidence-based osteopathy improves patient care; (ii) Evidence-based practice is a welcome development in osteopathy; (iii) Research findings are useful in my day-to-day management of patients; (iv) an emphasis on evidence-based practice will undermine important aspects of osteopathic practice; (v) Every osteopath has a duty to keep up-to-date with research and evidence about osteopathic practice.

We found that male osteopaths were significantly more likely to be 'pro-evidence based practice' (mean 3.36 vs 3.24 for female) and there was a significant *negative* association (-0.107) between time qualified as an osteopath and being 'pro-evidence based practice'; in other words more recently qualified osteopath were more in favour of evidence based practice).

In sum, while osteopaths' experience and continuing client base suggest that osteopathy is beneficial to many patients, there this is little hard evidence underpinning the way osteopathy works or supporting its efficacy, which perhaps led to a sense of insecurity and defensiveness among some osteopaths about their profession. Many osteopaths noted that the nature of osteopathic practice, and difficulties objectively describing how it works or its effects, meant that osteopathy was not amenable to conventional approaches of developing research and evidence (like randomised control trials, RCTs), although some osteopaths we interviewed wanted osteopathic RCTs to be conducted. The results of our survey echoes interviewees' views, suggesting than while the majority of osteopaths support the idea of evidence-based osteopathic practice in principle, fewer are positive about its effects in osteopathic practice. We also found that men and more recently qualified osteopaths were more positive about evidence based practice. The limited evidence-base relating to osteopathy creates some challenges for osteopathic regulation as we will discuss in the following section on osteopaths perceptions of OPS.

Summary

In this section we have discussed what the practice of osteopathy is, the nature of the osteopathic professional identity, and the limited evidence of the benefits and risks of osteopathy.

There is no agreed definition of osteopathy, and osteopathic practice ranges from a quasi-medical structural practice to more esoteric healing. Some osteopaths believe osteopathy is distinctive from other manual therapies (like chiropractic and physiotherapy) other osteopaths think that there is overlap between them. Osteopaths commonly agree on a holistic, patient-centred approach to patient care, the importance of their hands for diagnosing and treating patients and that osteopathy can help patients' bodies to heal themselves. Subjective feelings, intuition and communication and relationships between osteopaths and patients are also important parts of osteopathic practice. The complex nature of osteopathic practice means that it may be difficult to objectively assess against standards.

Being an osteopath and helping patients was an important part of their identity for most osteopaths we interviewed. Osteopaths also noted that their osteopathy practice was a business and osteopaths competed for patients with other clinical professionals. For many, being able to work flexibly and independently, outside large organisations like the NHS, was important.

We also noted limited evidence of the benefits and risks associated with osteopathic practice. While osteopaths' experience and ongoing client based support their belief that osteopathy is effective practice, the lack of evidence appeared to be a source of professional insecurity for some. However osteopaths noted that the complex, relational and holistic nature of osteopathic practice is not amenable to conventional approaches conducting research and developing evidence, such as randomised control trials used in medical and pharmaceutical research. Osteopathic evidence needed to be developed in ways appropriate to the practice. The results of our

survey suggest that while most osteopaths support evidence-based practice in principle, fewer are positive about its benefits for their day-to-day practice.

4. Perceptions and experiences of Osteopathic Practice Standards

While most osteopaths believe osteopathy benefits patients, the complexity of osteopathic practice, limited evidence of its risks and efficacy, and the independent nature of the osteopathic practice may make assessing osteopathic practice against standards difficult, as we noted in the previous section. In the following section we examine osteopaths' experiences and perceptions of osteopathic standards.

Positive perceptions of Osteopathic Practice Standards in general

The GOsC introduced osteopathic standards ('Standard 2000'[3], sometimes referred to as 'S2K' – distinct from the GOsC's Code of Practice, which operated in parallel) in March 1999 and consequently published updated 'Osteopathic Practice Standards'[4] (OPS) in September 2012 (see Appendix 1 for more discussion). Most osteopaths appear familiar with OPS; 76% of osteopaths responding to our survey agreed that they were 'familiar with the current OPS' (only 7% disagreed).

On balance, osteopaths appeared more positive than negative about OPS. 44% of osteopaths responding to our survey agreed that 'the OPS reflect what it means to be a good osteopath' (21% disagreed). However relatively few osteopaths (21% agreed; 48% disagreed) said they 'have changed what I do as an osteopath as a consequence of the introduction of the new OPS in September 2012'. The OPS were perceived to be a significant improvement on Standard 2000, which were seen as somewhat rigid and prescriptive, because they better reflected osteopathic practice. As one osteopath noted:

> *"S2K was OK … a little bit limited… a good start for the professional… The OPS is a huge leap forward."* (5.14G)

[3] https://www.**osteopathy**.org.uk/uploads/**standard_2000**.pdf
[4] http://www.osteopathy.org.uk/practice/standards-of-practice/

We asked osteopaths we interviewed about their perceptions of standards, what they found useful about standards, and if any standards were particularly useful or problematic. Overall, many osteopaths found the OPS helpful but no particular standards stood out as being more useful than others, although some interviewees commented that new standards relating to professionalism, communication and chaperoning were especially helpful. One osteopath commented that OPS provided:

> *"… guidance to my practice… it protects me… protects the patient … makes me at ease, because… I don't have to guess what I need to do. It is telling me the way I should conduct myself… professionalism should be the centre of everything really… the new Standards [are] easier to follow." (8.5O)*

So OPS were seen by some osteopaths to provide guidance that reduced the need to "guess" what professionalism involved, protection for osteopaths and patients, and put osteopaths more "at ease" that they were practising as they should. Similarly, the osteopath below described how the OPS provided reassuring guidelines, boundaries and a benchmark against which professionals individually and collectively and their patients could evaluate good osteopathic practice:

> *"Osteopathic Standards… I don't see it as particularly punitive. I see it more as... knowing the scope of your practice, boundaries, guidelines ... to, not only regulate or look after you as a professional person but also the patient. I think if you are clear about those boundaries then you can practice and work with confidence... Within that there is a great big broad spectrum in which you can be autonomous in the way you work… It helps you keep to professional standards … [and] your profession to know that they are practicing in the same way. It is a benchmark." (16.4 G3)*

Another osteopath suggested standards provided a professional "benchmark" against which to compare the quality of practice, which was particularly useful for sole practitioners:

> *"A lot of them are common sense for a good practitioner… based on good practice of a good practitioner… For the profession as a whole they are a useful benchmark … to keep people on track, particularly sole practitioners… When you have been a professional a while it is quite easy to drift, if there is no reference point to… the new OPS are well written… I am … in agreement with them." (4.29 G2)*

Another osteopath suggested that many osteopaths had unconsciously internalised standards:

> *"You are constantly thinking about them [OPS] because from the minute you open the door, how you greet the patient… so it meets GOsC standards and that it is safe… Standards come in, in the way that you are taking your notes and recording the important things during your session. So I think a lot of it is probably so embedded that you don't consciously think about it." (4.29 G1)*

Thus osteopaths may not be fully aware of the extent to which their practice complies with the OPS.

We asked the osteopaths we interviewed to describe their last session with a patient. Then, in the following discussion of what had influenced on the approach they took, we explored whether they had drawn on the OPS. We found a range of experiences. Some osteopaths "were constantly thinking about" (4.29G1) standards, some believed they were "unconsciously" or "automatically" aware of standards "in the back of their mind" (5.7Z2). Other osteopaths described their approach was more driven by their training, patient needs and communication with the patient, so while their practice complied with the OPS they did not think about standards. Many osteopaths did, however, explicitly mention taking consent from patients, which appears to have been particularly driven by standards. Thus while standards do have some impact on osteopaths, making a judgement about the extent to which osteopaths' practice is driven by standards is difficult.

On occasions, some osteopaths were very conscious of standards; one interviewee explained how, as a new osteopath, having standards had enabled them to resist pressure from other manual therapists to see a higher volume of patients by neglecting important osteopathic practices:

> *"I suddenly had full-time employment as an osteopath… They [the practice] had a 20 minute list and there were 14 of them [manual therapists]. They said: "… you don't need to do all the medical history." But I [said]… "No, we do need to do this and this is part of our thing [in osteopathy]." So I managed to get a 40 minute slot a double for new patients and 20 minutes for returning patients. So I had to really go to the Standards… to fight my way." 11.7G*

Thus OPS also enabled osteopaths to invoke higher professional authority to counter demands from non-osteopaths to cut corners or lower the quality of care they provided.

In sum, many osteopaths were positive about OPS providing guidance and a benchmark for osteopaths individually and collectively. Osteopaths' views varied considerably about the extent to which they were consciously, unconsciously or not influenced by the OPS during the course of their practice; some always thought about them, some did so unconsciously, whereas others said they never did, instead drawing on their training and patient needs and therefore only complying with OPS because they coincided with what they considered good professional practice. So judging the impact of OPS on osteopaths' practice is difficult.

Judging compliance with standards

Many osteopath interviewees felt they had a good sense of whether they or their colleagues were complying with the OPS. 49% of respondents in our survey agreed 'I

have a clear sense of whether I am complying with the OPS while practising as an osteopath' (while 18% disagreed), although one in four (25% agreed; 34% disagreed) agreed 'I find it difficult to demonstrate that what I do as an osteopath complies with the OPS'.

Our exploratory factor analysis indicated an aggregate factor for 'Feeling Compliant with Standards' (Factor 3; mean response 3.34, where 5 indicates strongly agree and 1 indicates strongly disagree) involving factors linked to the questions: (i) 'I have a clear sense of whether I am complying with the OPS while practising as an osteopath'; (ii) 'What I do as an osteopath always fully complies with all the OPS'; (iii) 'I find it difficult to demonstrate that what I do as an osteopath complies with the OPS', (iv) 'I am familiar with the current OPS', and (v) 'Complying with the OPS restricts my ability to provide care that I believe would benefit patients'. We found no significant associations with any demographic variables we analysed. However it is interesting that being familiar with the current OPS and always complying with the OPS should be also be associated with 'having a clear sense' and also finding compliance with the OPS 'difficult to demonstrate' and thinking that complying with the OPS restricting 'ability to provide care that would benefit patients'. Thus the factor analysis data suggests compliance is either a felt sense, which is difficult to demonstrate, or osteopaths who think more about how to rationally demonstrate compliance are more likely to doubt whether they are compliant.

We asked interviewees to articulate how they judged their own and colleagues' practice against standards but few were able to do so: "*I don't know… it is a bit woolly" 6.6Z1)*, instead referring to "*common sense and judgement" (04.23Z1) and "gut feeling… or a conscience*" (4.16G2). One interviewee comment that it was: "*Very, very difficult, because it is judgement based and it is not criteria based… The thing that we always used to say: "Would you send your grandmother to this practitioner?" And if the answer is 'no' then clearly something is not right*" (5.14G).

Another osteopath remarked that it was: "*messy… and whether … that messiness can be unravelled simply by the use of the Standards as the criteria I doubt*" (5.30Z),

which raises questions about whether it is possible, or not, to evaluate osteopaths' compliance with standards in any more 'scientific' or' 'rational' sense. One osteopath suggested judging compliance with standards was only possible through communication with osteopathic colleagues or by "struggling" with clinical audit:

> *"It is just me as a sole practitioner, it is very hard. You can only really... reflect on ... compliance with Standards. I can only judge what I do by my communication with other osteopaths in my CPD Group meetings. I don't know. Unless I do more things like a more structured 'clinical audit-type thing' – which I know we are all struggling with." (16.4G3)*

Another interviewee from an OEI suggested they could judge whether a colleague was meeting OPS using a tool for assessing students:

> *"I probably would use some sort of tool that we currently utilise here with our students. Where we have a set of ... a spreadsheet which includes clinical competency and it has the Standards mapped out against those" (05.01 Z2)*

However wider ambiguity around assessing compliances with standards suggests that there may be limits to osteopathic assessment and self-assessment. We note that most osteopaths' practices are independent businesses. Osteopaths talked about the 'market' providing a form of regulation for osteopaths; bad osteopaths are less likely to attract and retain patients and go out of business. Some osteopaths believed that if their patients returned for treatments and recommended them to others then their practice was judged adequate, suggesting a more 'customer' or 'market' oriented regulation of performance:

> *"I do get a lot of patients recommend their family to me, and I get a lot of… repeat business. So I feel from that I must be doing something right, because otherwise I would never hear from them again." (5.1Z1)*

The difficulty associated with potentially contrasting interpretations of whether osteopathic practice was complying with standards was, however, a source of anxiety for some osteopaths, who feared that, despite their best intensions, they might be judged as non-compliant with standards if subject to a GOsC investigation (also see the section on experiences of FtP hearings). One osteopath noted:

> *"The concern is that you do something that does upset someone and they make a complaint and then the GOsC have a look at your notes and says: "Well you didn't follow the guidelines to the letter" … I am actually quite fearful of that, because I try very hard to be… appropriate and very professional, to stick to the guidelines. But one's interpretation and other people's interpretation, you never know what is going to upset somebody." (4.15 O)*

Other research (Mulcahy, 2003, McGivern and Fischer, 2012, Fischer and Ferlie, 2013) has similarly highlighted professionals' fear and consequent defensive approach to regulatory compliance. However, only 27% of respondents to our survey agreed that 'the quality of patient care I provide is diminished because I practise defensively as a consequence of osteopathic regulation' (45% disagreed). In summary, whether osteopaths' were complying with OPS was a very difficult judgement. Our factor analysis (relating to Factor 3: Feeling Compliance with Standards) also indicated that osteopaths who believe their practice complies with standards, and are most aware of the OPS, also make this interpretation on the basis of a feeling, and would find rationally demonstrating compliance difficult. We found no significant variations by demographic criteria in relation to this Factor 3.

In sum, while many interviewees and half of the osteopaths in our survey noted having a clear sense of whether their own and colleagues' practice complied with standards, this appeared to be a tricky judgement, which was difficult to rationally demonstrate.

Criticisms of Standards

Some osteopaths were more critical of OPS, noting that they were ambiguous, unproven by evidence, and could lead osteopaths to go "over the top" in terms of patient safety to the detriment of healing patients, which provide a justification for non-compliance:

> *"Osteopathic Standards they are so broad and anything can be read into them… if you show that you are being safe and covering all your bases you can go over the top on this and actually be detrimental to the healing process…. Until those Standards have been proved to be workable they can only be guidelines." 24.6G*

A representative of the British Osteopathic Association also expressed concern that OPS were too oriented towards patient safety rather than improving the quality of practice:

> *"My concern basically is that at the moment the Osteopathic Practice Standards' … primary purpose is patient safety. They are adhered to by colleges who are compliant... [but] are we just making safe osteopaths or … good ones?" (7.3O)*

The results of our survey provided some support for the wider prevalence of this view. 38% agreed (21% disagreed) that 'The OPS should put greater emphasis on clinical effectiveness rather than clinical safety' and 26% agree (37% disagree) that 'Complying with the OPS restricts my ability to provide care that I believe would benefit patients'.

From our survey, it appears that one in five osteopaths believe they do not always comply with the OPS (45% agreed and 19% disagreed that 'What I do as an osteopath always fully complies with all the OPS) and almost one in four osteopaths do not always think about the OPS when treating patients (48% of osteopaths agreed

and 23% disagreed that 'I always think about the OPS whenever I am treating patients'). As noted earlier (in relation Factor 3 to 'Feeling complaint with standards') this judgement was more of a felt sense that was difficult to demonstrate.

Several osteopaths we interviewed acknowledged that they did not always comply with OPS. One, for example, commented:

> *"I don't comply with the standard in many of the things that I do… The standard is not realistic… Case-history taking, consent, modesty... for me, it is impossible to comply with those regulations and I break some of them every day… Particularly the recording; you cannot record the subtler things that we do and to write down that I have obtained the patients consent to do so-and-so is utterly pointless, because in law, informed consent is impossible to obtain. Whatever you say or whatever is written the patient can come back five years later and say: "yes I signed the form but I didn't understand it, so therefore I wasn't informed". So it is a lot of bureaucratic nonsense." (9.4G)*

This osteopath contrasts the contingency of osteopathic practice, involving complex human interpretations and interactions, with the "bureaucratic" nature of standards to justify their non-compliance with standards. The osteopaths also questioned whether the black and white nature of standards relating to boundaries in osteopathic practice:

> *"That I shouldn't be sexually attracted... I can't help it; I am a human being. But I need to be aware of this and act responsibly… There is a huge line between saying this patient or student is attractive and then sleeping with them… If I have got a patient who is in distress, my arm will be around [them] - and I hope not too sexually – but there is that interaction, and that is what we all crave and that is why people come to people like me. How can you draw lines if it is … acting within the best interests and not taking advantage?" (9.4G)*

They suggest that osteopaths' judgement about whether they were acting in patients' best interest was more important than complying with standards.

In our survey, 42% of osteopaths agreed 'The OPS reflect an overly medical view of osteopathy, (19% disagreed). More significantly, the majority of osteopaths, 58% agreed 'The OPS reflect an overly legalised view of osteopathy' (only 14% disagreed). We asked osteopaths why they complied with the OPS. Relatively few osteopaths (28%) 'comply with the OPS because they reflect what it means to be a good osteopath' (35% disagree). 49% agreed they 'comply with the OPS to avoid getting into trouble with the GOsC' (22% disagree) and. 54% agreed they 'comply with the OPS to protect myself from being sued by a patient' (only 16% disagree). So complying with OPS appears more motivated by defensive practice than because osteopaths believe doing so reflects good practice. So osteopaths were almost twice as likely to say they complied with the OPS to avoid getting into trouble with the GOsC or being sued by a patient than because they reflected good practice.

Our exploratory factor analysis indicated an aggregate factor relating to 'Fear-based compliance with regulation' (Factor 6; mean response 3.32 where 5 indicates strongly agree and 1 strongly disagree) comprising three factors linked to the question: (i) 'I comply with the OPS to avoid getting into trouble with the GOsC', (ii) 'I comply with the OPS to protect myself against being sued by a patient' and perceptions of the GOsC being affected by (iii) 'My fear about what the GOsC could do to me or my osteopathic practice'. We also found a significant *negative* association (-0.074) between time qualified as an osteopath and defensive practice (Factor 6) (i.e. more recently qualified osteopaths are more likely to comply with regulation to avoid trouble with the GOsC, being sued by a patient or out of fear of the GOsC).

Problematic standards

Osteopaths appeared less likely to comply with standards that they did not believe made sense. One we interviewed noted:

> *"You want to obey the spirit of the law but sometimes the letter of the law just is a bit nuts… there are certain regulations… I think no, I am not doing that, because that is just a nutty regulation." (6.6G2)*

While osteopath we interviewed did not single out any specific standards more helpful than others they did express concerns with three areas in relation to standards in particular: (i) informed consent and communicating risks with patients (ii) note taking, sometimes relating to noting consent and (iii) patient modesty.

(i) Informed consent and communicating risks

The Chester vs. Afshar (2004) court case (relating to the Human Rights Act 1998) ruled against a surgeon for not informing a patient of the risks associated with a surgical procedure he carried out. This case established case law obliging all clinical professionals to inform patients of the risks associated with treatment they carry out. Following this case, the GOsC introduced 'Clause 20' into its osteopathic Standards 2000, which stated: 'You should not only explain the usual inherent risks associated with a particular treatment but also any risks of seriously debilitating outcomes.'

While the GOsC attempted to address osteopaths' concerns about 'Clause 20' when it produced the revised OPS in 2012, many osteopaths, particularly those who practiced alone, voiced concern and confusion about standards obliging osteopaths to gain informed consent from patients before carrying out any osteopathic procedure. Many osteopaths found this was difficult because there was insufficient evidence of risks linked to osteopathic treatments. As one solo osteopathic practitioner noted:

"Many of... us [osteopaths] were concerned about Clause 20… the discussion of… possible reaction and side-effects to treatment, no matter how remote, based on the House of Lords ruling against a surgeon who didn't explain the very small risks associated with the procedure he was about to undertake[5]*… It is difficult to quite know how to comply with that as a regulation, when the relative evidence [is]… difficult to say … The perception was that we were being asked to give [patients] the likelihood or the kind of figures… of the risk for immobilising someone's upper neck and we didn't have those figures available. And then some of the information we were getting back, saying it [particular osteopathic treatment] is no more dangerous that putting your head over a sink at the hairdressers, is fantasy. It is an unknown. So that was quite difficult to comply with." (3.24O)*

Similarly, another osteopath noted:

"Was it Clause 5 or Clause 20 – gosh I can't remember now… Any risk, no matter how small [you have to tell a patient]… It drove us crazy… there is still a difficulty in identifying the frequency of these events." (5.6G1)

So the standards relating to informed consent were perceived to be both impractical and unworkable on one hand; whilst also meaningless, given the lack of evidence about risks associated with osteopathy.

Other osteopaths (who also practised alone) believed that patients often struggled to conceptualise risks:

"There wasn't the evidence in an accessible form … to actually fulfil the consent process with a patient, without scaring the living daylights out of them. We don't know the risks of all the treatments … If I were to say to you...

there is a one-in-a-million chance I could kill you, then yes, you probably would be out the door sharpish. But I think it is how you couch that information, and making it relevant. We know there is a one-in-fourteen-million chance we could win the lottery but actually what does that mean? Those big numbers are very hard for people to get their head around in a meaningful way." 29.4G2

Some osteopaths were concerned about unnecessarily frightening patients by telling them about remote risks, which might perversely undermine patient safety:

"To get informed consent you have to give them all the possibilities of reactions to any treatments or any technique. And I feel that if you are going to scare the living-willies out of someone, saying that they are going to die, they could die after a technique, because once it happened, it would be such a negative thing and it could actually make the technique dangerous." (6.24G)

Other osteopaths worried discussing the risks associated with osteopathic treatments, where there was insufficient evidence, might frame osteopathy in biomedical evidence-based and unnecessarily undermine the credibility of how they were treating patients:

"Explaining what you are going to do is not a problem, but sometimes explaining the rationale behind doing it is, because there isn't the evidence base to back it up." (1.5Z)

While the GOsC were obliged to implement 'Clause 20' to comply with case law, some osteopaths interpreted these standards relating to informed consent as symptomatic of regulators being removed from the "real world"; developing standards perceived to be ill suited to osteopathic practice or patients. While one function of regulation is to maintain the social legitimacy of osteopathy by bringing osteopaths in line with wider changes affecting health care, which many osteopaths

were otherwise isolated from, having to implement legally-driven but overly generic standards undermined the credibility of osteopathic regulation:

> *"A lot of regulations are like that, it happens in Health and Safety and in Occupational Health, where someone in an ivory tower writes a rule and doesn't have any idea of what the real world is like… I do sometimes jokingly say to patients – 'one of the things I am supposed to tell you is that 1 in 14 million people when they have their neck adjusted will end up with a stroke. I haven't got anywhere near 14 million patients so it is unlikely that you are going to be the one'. Most patients' response is: 'I really don't want to know that'. (23.4O)*

Some osteopaths had changed how they communicated with patients to formalise informed consent as a result of the introduction of the OPS. One noted:

> *"What I do actually, which has come about from GOsC Standards, it is about communication... new patients … I send out a joining letter explaining what will happen. A bit about osteopathy, what will happen at the first appointment and what to bring … I put it in writing, 'if there is anything you wish to ask about then please do'. And also they have to sign a consent form. I take a written consent. And I send it out before… for me the biggest change is formalising informed consent." (6.6G1)*

Another osteopath, also a lone practitioner, believed that osteopathy was generally safe so informing patients of remote risks was unnecessary:

> *"I don't talk about risks... generally what I do is fairly safe … treatment reactions are usually fairly short-term … So I tend to… say … "You might feel more tired or a bit achy … if [reactions] lasts more than twenty-four hours let me know." (4.16Z1)*

One osteopath, who had sat as a member of a FtP hearing, noted the high number of FtP cases relating to poor communication and informed consent, and consequent resentment of related Clauses. They suggested that there needed to be better support mechanisms to help osteopaths explain risks and gain consent from patients:

> *"I also sat as a member on Fitness to Practice [Committee] and it is quite evident that a number of cases that came to the Fitness to Practice hearings were because of poor communication. So it is not the competency of the individual; it is the way this individual has communicated or not communicated. Telling the patient what you are going to do, why you are going to do it, and what are the possible consequences and this issue of consent." (5.14G)*

The osteopath went on to highlight the importance of evidence (as discussed above) and education and training (about how to communicate risks) to support the implementation of some new standards, which they suggested was lacking with Clause 20 was introduced:

> *"When the Clause came out, there was no support mechanism to support osteopaths and to say 'how you can do this'? And one of the biggest challenges … driver behind this resentment to Clause 22, is the lack of evidence. So classically osteopaths use a technique called high velocity thrust technique which produces a clicking sound… it can cause stroke or paralysis, the risk is so little you have got a higher risk from taking NSAIDS than from this, but you only have to have one case. There is a risk. The most common risk is that you will be sore for 12 hours or 24 hours." (5.14G)*

The osteopath suggested that that there was an appropriate way to explain risks to patients:

"The worst thing that could happen is... however, I have been doing this for x number of years, and I haven't had a case. And the reason I am deciding to do this is because I have asked you the right questions and I have examined you for half an hour… and I feel that there is no contraindication that I can see." And let the patient decide." (5.14G)

However the osteopath suggested that many osteopaths feared losing patients if they communicated to patients the risks, however unlikely, of osteopathic treatments:

"The attitude of my colleagues out there is to say: "As soon as you tell somebody … 'I am going to do something… that might be going to kill you', then the answer is going to be no. When Clause 22 was published … there was a huge amount of fear from osteopathy [that] if we say this, then suddenly we won't have any patients." (5.14G)

However, again, the osteopath suggested that relative risks could be communicated to patients in a way they could understand. For example:

"If you are going to cross the road this week, there is a risk that you will get knocked over and killed. Would that stop you crossing the road? No. Well there is a 10 times greater chance of that happening than if I do this [osteopathic] technique. Are you comfortable for me to do it? Or would you rather think about it? … Putting it in those terms they will say 'oh, I see what you mean'. Understanding the relative risk is very important." (5.14G)

In sum, many osteopaths were frustrated by standards relating to informed consent and communicating the risks associated with osteopathic treatments. This was first, because the need to do so originated in a setting far removed from osteopathic practice (a legal case relating to a surgical procedure), so it was seen to be driven more by abstract legal requirements than what osteopathy patients wanted or osteopaths were able to do. Second, osteopaths suggested that the risks associated

with osteopathic techniques were unknown, due to the lack of evidence relating to osteopathy, and remote. Therefore they perceived doing so too difficult, unnecessary and even harmful to patients. Given the need to comply with legal requirements, and until sufficient evidence is developed to be able to know risks associated with osteopathic techniques, these problems may remain. However communicating to osteopaths more clearly, and providing more training, about how to communicate risks to patients (without scaring patients) may helping osteopaths who struggle communicating risks and gaining informed consent.

(ii) Note keeping

A second issue osteopaths often struggled with was note keeping, including noting providing informed patient consent. Many osteopaths commented that osteopaths who had complaints made against them investigated by GOsC were often admonished for poor note keeping, even if the original complaint against them was dismissed. One osteopath noted:

> *"The big consent issue… it is not necessarily that they haven't gained consent from their patient but that they have not ticked the box on their consultation form or written IC or something or some sort of note taking that they have actually gained consent from the patient. And it seems every one that gets pulled up for something… [Even when a patient complaint is dismissed] the osteopath is still put through this huge amount of distress because they didn't put IC." (17.4O)*

Another believed that the regulatory preoccupation with note keeping was misguided because notes did not necessarily reflect practice:

> *"Harold Shipman recorded lots of things but he obviously wasn't doing them… you could record in your notes that you had got verbal consent from the patient [when you had not]." (29.4G2)*

Thus some osteopaths perceived that regulators were more concerned with bureaucratic 'tick-box' compliance, than the ways in with regulation improved osteopathy in practice, reflecting previous research on medical regulation (see, for example, McGivern and Ferlie (2007) on the introduction of NHS consultant appraisal). Some osteopaths commented that they struggled to keep notes while examining and communicating with patients in the time they allocated for patient appointments:

> *"I find it an increasing challenge to write down, examine the patient and write down what is normal … Still after thirty-five years, I struggle to get talking nicely to the patient – examining and writing it all down in the time.... it is hardly manageable" (6.6G).*

Osteopaths expressed fear and insecurity about potentially ambiguous interpretations of adequate or inadequate note keeping, again reflecting previous research on the regulation of other professionals, such as medicine (McGivern and Ferlie, 2007, McGivern and Fischer, 2012, Lloyd-Bostock and Hutter, 2008), which produced defensive practice:

> *"You do need notes... so that you can read them yourself and defend yourself in court, if ever there as an incident … heaven forbid! … The problem is that there is a fear... practitioners are fearful... A lot of urban myths that float around, about if there is a complaint… And it is not just complaints, it is disproportionate… Obviously you don't want Shipman and you don't want people who are really incompetent or dangerous. But sometimes... practitioners … feel that … in normal court cases you are innocent until proven guilty… But … they feel … guilty until proven innocent… [particularly in relation to] note taking, which is the bane of all our lives; we are all guilty at some point of one of our notes not being perhaps as perfect as they should be." (23.4ZS2)*

Some osteopaths believed that having to keep notes undermined their professional autonomy and detracted from their relations with patients:

> *"Having to write down prescriptive things for every single eventuality, takes away your autonomy as a practitioner, and your ability to develop your relationship to your patient" (6.6G2)*

In sum, standards relating to note-keeping were seen to be problematic for a number of reasons. First, some osteopaths perceived note-keeping to be more about 'tick-box' regulatory compliance than improving the quality osteopathic practice and professionalism. They noted that exemplary records kept by Harold Shipman[6] and at Mid-Staffordshire NHS Trust[7] did not indicate the poor quality of actual care provided. Second, osteopaths expressed concern that focusing attention of note-keeping might distract osteopaths from examining and communicating with patients, or produce defensive practice, in a way that might undermine the quality of care. Third, and perhaps most significantly, osteopaths worried about the ambiguous ways in which their notes might later be interpreted in a FtP hearing, so that even if their practice was found to be high quality, and they believed they were keeping notes as specified by standards, osteopaths would be found guilty of professional misconduct.

(iii) Patient modesty

The final issue relating to standards that osteopaths complained about related to patient modesty. The standards specify that osteopaths should 'respect patients' dignity and modesty' and be 'sensitive' to patients wishes but acknowledge that patients circumstances vary and that osteopaths need to accommodate these variations. However, many osteopaths expressed confusion about whether they were required to leave the room whenever patients undressed, even if the patient did not ask for this or it was not appropriate. One female osteopath commented:

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[6] http://webarchive.nationalarchives.gov.uk/20090808154959/http:/www.the-shipman-inquiry.org.uk/reports.asp

[7] http://www.midstaffspublicinquiry.com/

"[My patient] started taking his shirt off and I didn't need him to take anything else off. And I was thinking about the osteopathic standards about leaving the room when the patient is changing. And I thought well, I don't know if that counts? I mean does just a shirt off count? … He is quite happy to just take his shirt off when I was there… Am I making myself vulnerable by not following it [standards] to the absolute letter? … I stayed in the room." (6.6Z1)

Osteopaths often noted that they found it useful to diagnose patients' conditions by watching them while they undressed, so worried that complying with these regulations might undermine their ability to treat them:

"The regulations about privacy when a patient is getting changed… that is obviously a very easy one to comply with… [but] we miss information sometimes, when we don't see a patient performing those daily functions of dressing and undressing." (3.24O)

Others suggested that rules relating to patient modesty were, reflecting discussion above written by people who did not understand osteopathic practice, because rules were neither always practically possible or what patients wanted:

"One little stupid rule… is this thing about 'you must have somewhere where the patient can dress and undress in private'. I understand the logic behind it but lots of us work in quite small spaces. And I have offered patients screens and most of them ignore the screen and still get dressed and undressed standing next to me. Technically I am in breach of the rules and regulations. And that is a prima facie example of rules and regulations being written by people who really haven't got a clue what the real world is like." (23.4O)

"I often have to stay in the room while the patient is undressing, because I treat so many older people that they actually need help with the undressing. So they don't actually want us to leave the room" (5.1Z)

"We have got a screen and gowns… nobody ever wants them… I say to people, 'Would do you like me to leave the room?' And they always say, 'But you are going to see me in a minute anyway." (21.3G)

Thus osteopaths perceived that breaking the rules relating to patient modesty was not only safe but also what patients wanted, or indeed what older patients often needed. Therefore, they believed these standards should be less prescriptive in black and white terms and more allowed to use them as prompts for reflection, judgement and risk assessment about what patients wanted and needed in varying circumstances:

"Should you leave the room for your patients to undress? I have patients who are frail I have patients who may fall over; I have patients who lose their balance. I have patients with disabilities… I say to them.... look if you are happy for me to remain in the room whilst you take your things off, then great, and I write it down… It is inappropriate and unsafe for some patients. Now, if somebody said, yes please can you go out, I would be happy to… everybody says to me – 'why would you go out if you are going to come back in?'... we need to be treated a little bit more as grown-ups in terms of being able to judge… who needs privacy and who doesn't." 6.6G2

Another osteopath, who practised alone, noted they would "ignore" what they considered "pointless" standards, in the case below relating to patient modesty, while reflecting on patient needs in particular circumstances, drawing upon their own sense of osteopathic professionalism to justify doing so:

"That is pointless … a standard I would probably ignore… some… patients … are quite elderly, so they may sometimes need a bit of help with dressing and doing up shoes and those sorts of things, so you can't say 'I am leaving the room to let you get on with it and if you trip over your shoe laces that is tough!' So it is about using a little bit of common sense and being perceptive

about what they [patients] need. Some patients … are obviously not very comfortable about being undressed and that is fine. But it is about having that dialogue. And if the standards make you think … reflect on whether the patient is comfortable then they are good from that perspective… reflection about what is right in a particular situation. The other thing that annoys people is this thing that you have to have a towel to cover your patients up... I have never used towels, and I don't intend to. But it is just about trying to be sensitive and respectful to patients and their particular choices… it is part of being a decent human being really." (29.4G2)

Similarly another osteopath, who also practised alone, similarly commented on their assumption of patient consent if patients took their clothes off:

"In terms of regulation I don't leave the room. I assume… they are giving their consent if I have asked them to takes their clothes off… I cover patients up if they are cold but other than that, I don't cover them up for dignity in any kind of sense like that. Unless they either express some discomfort that ... or show that they are looking uncomfortable." (16.4Z1)

The osteopath believed that being sensitive to patients and respecting their gender, cultural and religious wishes and making a judgement about what is appropriate in local circumstances in line with a sense of osteopathic professionalism, was more important than complying with black and white standards:

"If you are treating people from other cultures, i.e. people who like to keep their clothes on and do not want to disrobe, that is kind of tricky because you need to see [patients], to some degree. But mostly you can negotiate around that. Certainly I don't think that is too difficult. I think that is important; if somebody is really uncomfortable that they are allowed to keep their clothes on and you just have to work with what is available". (16.4Z1)

As an interviewee from the GOsC noted that, while osteopaths were very comfortable with and used to people being in a state of undress, they may not always realise that some of their patients were not:

> *"In osteopathy, where nearly all examination treatment takes place with the patient wholly or partly undressed or mostly just in their underwear…. Osteopaths… learn this in school, are completely… open to this. They spend the first two years... in their technique classes in a state of undress with each other… and then… practicing with patients for twenty or thirty years... taking their clothes off… The work we did on patient expectations a few years ago, I was really, really critical ... because it gives you some evidence to say… You may think that your patients are happy to strip off the minute they walk through the door, but actually some of them are telling us that they find it a bit uncomfortable." (9.5G)*

Research (Leach et al., 2011) suggests that differences between osteopaths' and patients' attitudes towards modesty may trigger complaints; so it is important osteopaths do not assume patients are comfortable removing their clothes.

In sum, many osteopaths, particularly those who practised alone, expressed frustration about complying standards relating to patient modesty, which they believed were too black and white, "pointless", "stupid" and often detrimental to patient care in certain circumstances, undermining their ability to diagnose patients or help elderly patients undress and dress. Thus some chose to ignore these standards (reflecting research suggesting that breaking rules can be consistent with patient safety, e.g. Waring, 2007), instead drawing upon their own sense of professionalism and sensitivity to patients' reactions and cultural wishes, to make a judgement about what was appropriate in particular circumstances. However, the standards specify that osteopaths should 'respect patients' dignity and modesty', be 'sensitive' to patients wishes and acknowledge the different circumstances that may affect patients. Accordingly, some osteopaths' (mis)interpretation of these standards is interesting; wider perceptions of regulation and worries about how behaviour

might be later (mis)interpreted in FtP hearings may as significantly frame osteopaths' interpretations of standards as what standards say.

OEIs role in promoting compliance with standards

OEIs appeared to play a key role in promoting standards among trainee osteopaths and consequently their implementation into practice. Interviewees from OEIs all noted in their curriculum: "*Everything is mapped…. to the Standards"* (4.16G3); *"Regulation creeps through training; the training schools have to train to certain standards and that is assessed… [against] the Osteopathic Standards documents." (17.4M); "Everything about what we do screams to me OPS"* (5.14G).

Many interviewees perceived that there had been recent improvements in the way OEIs taught students about OPS:

> *"There were huge variations … between the standards in the schools and what was taught. And that is now much, much better. So that is a good positive again for regulation." (4.16Z2)*

Interviewee from an OEI noted how osteopathic undergraduates learned to engage with standards by using them while working with patients, problems, writing their dissertations and learning research methods, so that it was "drip-fed into their psyche":

> *"We kind of map the curriculum to the OPS... they are engaging with real people and with real problems and … engagement with the OPS comes, just through … doing it and the tutors are there as role models and mentors and guides to kind of help with that process… We … map our dissertation and research methods and… revised curriculum documentation… learning outcomes to the OPS… it is kind of drip-fed into their psyche" 23.4G*

Another OEI-based interviewee commented that, by working with the OPS throughout their training, osteopathy graduates could be confident that they met the standards required by the regulator and able to engage with ongoing osteopathic regulation:

> *"Our [curriculum] used to be against S2K and now it is against OPS…. It is not a remote document… [Students] have… to work with it. It … gives them a sort of confidence that the education and training they have received here has been sufficient… that they have done all of the things that were required of them according to the Regulator. And the final thing is that it did look like the revalidation might use OPS and Self Audit as part of the tool kit. And we wanted students to graduate from here being absolutely ready to engage with that." (5.6G1)*

Clearly, then, OEIs play a key role in ensuring compliance with OPS among new osteopaths. Research by Freeth et al (2012) on *New Graduates Preparedness to Practise* found new osteopathic graduates often emerged from their training 'safe if not always effective' and that learning often continues while practising as a registered osteopath. There is a risk that too much emphasis on learning standards, rather than to be an effective osteopathic professional, may restrict new graduates' ability to learn to be better osteopaths or to respond to future changes in osteopathic standards. Complying with OPS can be seen as a basic entry level for osteopathic practice and more experienced osteopaths may become unconsciously competent or develop a tacit osteopathic competence, which enables them to think less consciously about standards while practising osteopathy.

However OEI interviewees also were supportive of the way in which they perceived that OPS promoted generic skills relating to osteopathic professionalism and communication, which might counteract overly standardised osteopathic training. As one OEI based osteopath noted:

"OPS … put the emphasis on this issue of professionalism… We had the Shipman thing and then the Francis Inquiry … professionalism became a key issue … Osteopathy is a very lonely profession… with very limited contact with others… To highlight … the issues of consent and boundaries… was important… The central plank in what we do, and from day one with our students, we say communication, communication, communication… both verbal and non-verbal. (5.14G)

OEIs interviewees described how students learned to work with standards through various modes of problem-based learning and media to bring standards alive:

"Students are encouraged, and do, explore the osteopathic standards… problem-based learning is a very good way of doing that… For example, a letter of complaint, an imaginary, anonymous letter of complaint and posing the questions: 'How would you deal with this?' 'What would you do?' 'What are the steps you would have to take? … Not just reading those standards, but actually bringing those alive. And having exposure to tutors who are in clinical practice and who can bring their experiences and learning from mistakes and from the good and the bad… We have used some of the videos … that exposed bad practice and good practice and a good scenario and poor scenarios and how you deal with that. So I think it is really trying to bring in different media, and different approaches, with the same message." 04.23ZS1

The OPS were also praised for their emphasis on promoting communication skills (both verbal and non-verbal) and reflective practice, generic skills that were valuable for all osteopaths:

"Communication, nonverbal and verbal, and reflective practice… are extremely important skills… the regulations are a fantastic framework for education... to develop students so that it [communication and reflective practice] is second nature to them." 04.23ZS1

Another OEI based interviewee ran a model designed to prepare students for practice, which involved a: *"professionalism task [to]… discuss an ethically challenging situation… write about it and to refer to the Professional Standards… reflective writing"* noting that students were: *"encouraged to refer to the Professional Standards, to demonstrate how they have used the Professional Standards and guidance." (16.4G2).* Another OEI-based interviewee described a session also designed to bring working with the OPS alive:

> *"3rd Year [students] have got a …. session … [on] managing complaints… They have to do a reflective kind of critical incident report… a letter …a mini review, and an audit … identified their learning action plans … look at what they are doing in terms of the practice standards and think about how they have covered each of these domains."*

The osteopath described how a student had complained that *"we don't want to write about being an osteopath we want to do osteopathy"* and how the tutor had explained that*:*

> *"This is the sort of skills that you have to be able to have in order to demonstrate all through your professional life…. so you might as well get used to doing it now"* and that *"if they have done this course, then dealing with GOsC regulation is fairly straight forward… They all moan about … Continuing Fitness to Practice… But … new graduates I think will be better prepared for this kind of thing." (23.4G)*

Our analysis of survey data also indicated that more recently qualified osteopaths were more likely) to believe that the 'OPS reflect what it means to be a good osteopath' (correlation -0.75) and that 'Osteopaths should be regulated by law' (correlation -0.94) and to demonstrate 'Fear-based compliance with standards' (Factor 3 – with a correlation of -0.74 between fear based compliance and time qualified as an osteopath.

Summary

In sum, OEIs osteopathic curricula were mapped against the OPS, which played a central role in osteopathy students' training, so that the OPS were "drip fed into their psyche". OEIs attempted to bring the OPS alive by getting students to engage with them during clinics, under the guidance of tutors, and during reflective exercises involving scenario where they needed to refer to relevant standards. Our analysis of survey data indicated that more recently qualified osteopaths are more likely to believe in the OPS and to comply with standards out of fear of what might happen if they did not (Factor 3). While there is a risk that focusing too much on standards may limit students ability to learn to be better osteopaths, OEI-based interviews noted that the OPS promoted generic traits and skills, particularly professionalism, communication and reflective practice, which were seen to underpin osteopathic efficacy.

5. Experiences and perceptions of the GOsC and regulation

In this section we discuss osteopaths' perceptions and experiences of regulation and the GOsC, explaining the ways in which these general perceptions frame osteopaths' perception of and responses to and compliance with standards.

We also note that relations between the GOsC and osteopathy profession were antagonistic in the past. Many osteopaths perceived that the GOsC had made mistakes relating to the introduction of Professional Profile and Portfolio **(**PPP). These past mistakes and conflict continued to affect some osteopaths' views of the GOsC. Interviewees noted:

"Osteopaths are, as a rule, there is a fair bit of suspicion and fear of regulation… They kind of think that the GOsC are imposing stuff on them just because they are sitting around thinking, 'What else can we get them to do?'" (23.4G)

"A lot of the venom that was directed towards them [GOsC] in the early days was because of this PPP process. And there are still people who feel scarred by what the GOsC did." (5.6G1)

"GOsC… say, please stop bringing up the PPP… but it was a painful experience … [GOsC] are in a very different place now to where they were 10 years or so ago, and we have to give them credit for that… we will keep trying not to dwell on the past!" (5.7Z2)

In our survey 46% of osteopaths agreed (31% disagreed) that their perceptions of the GOsC were based on 'fear about what the GOsC could do to me or my osteopathic practice'. So past initiatives have a legacy effect and need to be accounted for; there is no blank slate for new regulation. Another interviewee noted:

"In the old days, when they [GOsC] pretended that they wanted to listen to osteopaths, the feedback was supposed to be going both ways but then they didn't really want to hear what people at the coalface really were saying" (4.23Z2)

The consequence of this historical legacy was:

"The trouble is the consultation process is ... a lot of us are wary; we feel that… they are consulting but the decisions are already made." (23.4Z2)

Another osteopath complained about the legalistic tone GOsC often used, suggesting the regulator needed to better communicate why certain legal requirements were necessary:

"A tone of communication, which is often condescending… explain 'this is why you need to do this' from a legal point of view. Not 'we are just trying to police you' – which is how it comes across. But actually the law requires us – the statute requires us to do this – this is the easiest way for you to do that and for us to comply with the law. But then sometimes the law is ridiculous." (6.6G2)

However other osteopaths still questioned whether people who weren't osteopaths could really understand what osteopaths do or therefore tell them what to do:

"[GOsC are] nice people up there, making sure the public are being protected against rogues.... I suppose there has to be regulation to acquire [professional] statuses ... that enhance your ability to get patients … My query is do the regulators know what osteopaths do? ... Regulators are… bouncing around between … registers ... I feel a little bit miffed that they are run by people like that who aren't… osteopaths sitting there, telling us what to do… on things ... they don't understand" (6.24G)

Thus perceptions of the GOsC and osteopathic regulation appeared to impact the ways in which osteopaths complied with regulation. Another osteopath suggested that regulation framed by suspicion of professionals created a culture of fear in which professional would start hiding what they do:

> *"The whole assumption on which that [regulation] is based is that everybody is a cynical Machiavellian character and can't be trusted to recognise the greater good… The huge problem with regulation [is that it is]… set up to catch the people who are trying to pull the wool over our eyes, the self-interested people ... evil or however you want to call them… The problem is that anyone who… truly has that attitude will find it incredibly easy to meet the regulatory requirements, because all you have to do is talk the talk… If you really are that cynical then that is easy… if the Standards of Practice are a box-ticking exercise… If your aim is to influence practice, the most important thing I believe … is the culture in the environments in which people train… If you create a culture of fear, people start hiding things…. treat people with suspicion they are going to act suspiciously… The problem is the attitude towards the practitioners… The more out of context that gets taken… the more nervous people feel and the more likely they are to do something stupid." (6.4O)*

However, one osteopath we interviewed suggested that such views were from:

> *"An element [within the osteopathy profession is]… whinging about things that happened years and years ago. And you just think, wake up, life moves on and I think the health-care environment is moving on fast and furious. I think we have to grasp the opportunities that are out there, because the landscape is changing." (29.4G2)*

Most interviewees believed the GOsC were doing a good job. Many interviewees suggested that GOsC had significantly improved in recent years. GOsC was seen to be

taking a more developmental and supportive approach to regulating osteopaths. As one osteopath noted:

> *"I have actually been very encouraged by GOsC lately… the work they have been doing on Continuing Fitness to Practice… is about creating an environment in which … that caring human part of us is nurtured." (6.4O)*

Others commented on how GOsC efforts to engage with osteopaths, often in person, was changing the way they were perceived; dispelling fears and fantasies about distant impersonal and malevolent regulators, with little understanding of osteopathy and intent:

> *"We got [GOsC CEO] and [GOsC Head of Standards] to come down to speak to the first years [osteopathy students]… That was really helpful, because… seeing a face, early on in their career, and realising that they weren't these kind of distant [regulators] … They were nice people, who talked to them about interesting issues… was good… engaging with the students from the start… They get out and … it is just trying to break down that fear and cynicism… in the profession… osteopaths generally lack understanding of what the regulation is about" (4.23G)*
> *"[There was] fear of GOsC in the profession… [Now] there is more realisation of the benefits of GOsC, [because GOsC staff] come out and speak to us, and we see people; … they haven't got horns on their heads, these regulators… They actually care about what they do… are quite bright… aren't osteopaths but they can understand what we do." (5.30Z)*

Osteopaths we interviewed also comment on GOsC "*communicating with the profession a lot better*" (4.16G2) and consulting and engaging in two-way dialogue with the profession about regulatory changes it was considering introducing:

> *"It is a sort of mutual kind of dialogue – they [GOsC] come and visit [OEI] and see the students… When you disagree over something you are not afraid to say… you are wrong … and you can have that conversation in a professional*

way… From my experience of meetings that are held with the OEIs at GOsC, they want feedback and they want us to tell them what we think. But they are not afraid to say what they, which might be in contradiction to what we think, and vice versa." (23.4G)

"The reason why I think that the GOsC is doing a far better job now, it is only one single reason. They are engaging extremely well with all the stakeholders… there needs to be a dynamic between the two [regulator and profession] and an active dynamic…. [Now we] understood what the registering body was trying to do, because there was … a profound lack of understanding of really what was going on… they are engaging at various levels. They take time to go to Regional Conferences… they are not going there as masters, they are very genuine and want to engage with the profession and explain what regulation is and why there are doing some of the things. This whole thing about consultation I think is a good thing… I am not saying that the current regime is bending over backwards to give us what we want. …This is not a one-way street and we realise that we have got faults… there is a real understanding now of where we are both coming from and what we are trying to achieve. And at the end of the day we are all in the same game of trying to produce good osteopaths who are safe and effective, and efficient within practice." (5.14G)

Thus it appears important that GOsC engages in dynamic multimodal two-way rather than one way top-down communication. Given the more individualistic rather than collective nature of osteopathy as a profession, individualised modes of communication may be more effective in osteopathy. Interviewees acknowledged GOsC's "difficult role" regulating osteopaths while working with the osteopathy profession to improve the quality of practice and "move the profession forward":

"There has been a really … big change in the way in which GOsC has moved over the last five years or so. All for the better... it is much more open and it is like it is all there to develop the profession… A few years ago… it wasn't like

that it was more like an 'us and them'. There was no kind of communication… GOsC have a difficult role because it is not so clear now, where they stand as the Regulatory Body… they need their professional body to be working with them … that is when it all gets a little bit difficult. But I can see that they are working very hard to move this profession forward". (16.4G2)

An interviewee form an OEI commented on receiving feedback on reports submitted to the GOsC, which meant that they now understood why they were providing information whereas under previous administrations they felt they were providing tick box for no valid reason:

"Now we get feedback on the work that we have done… filling out the Annual Report … In the early days we all talked openly. Whatever we are sending is going into a black box. You [GOsC] haven't looked at it, you haven't read it, and it is gathering dust somewhere. Now with a QA we get a report… and feedback and this is welcome, and that is positive…. So next time we are doing this report, we say, 'Yes this is important, let's get feedback on it'. So [previously] we felt that there was a lot of information that we were filling in that we couldn't see any reason for... it was information for information's sake. And it bore no sense of reality." (5.14G)

Interviewees suggested that professional engagement was key to implementing effective regulation; that osteopaths needed to understand why new regulations or standards were being implemented, otherwise they would interpret new regulation in different ways likely to produce defensive practice:

"For regulation to be effective… as far as osteopathy is concerned effective clear engagement with the profession [is necessary]… If they are going to set any rules or regulations or standards, then communicate and explain that to the profession. It is human nature. If somebody doesn't understand they will always perceive this as a stick. So there is a constant feeling in the profession, 'here we go again, the GOsC trying to force us into something and pushing us

into defensive practice'. But they don't realise that GOsC have their own masters. So, standards – rules – codes of practice are all essential. But they need to be clear… unambiguous and with an explanatory note of why they are doing this." (5.14G)

This quote reflects the findings of previous research (Quick, 2011) suggesting that professionals are more likely to comply with regulation if they understand and accept the reasons for it as legitimate.

We asked questions in our survey about osteopaths' perceptions of the way the GOsC communicates with the osteopathy profession. 43% agreed that 'The GOsC communicates well with osteopaths' (26% disagreed) and 36% agreed that 'The GOsC consults well with osteopaths' (29% disagreed). Most osteopaths' said their perceptions of the GOsC were based on 'GOsC communications' (73% agreed; 5% disagreed); 'experience of the GOsC' (65% agreed; 9% disagreed); and 'what I hear from professional colleagues' (60% agreed; 16% disagreed). We wondered whether osteopaths perceptions might be based on 'what I hear about regulation in the news' but few (21%) agreed (the majority disagree 55%). So communication, consultation and experience of regulation are things the GOsC needs to focus on to affect change in osteopaths reactions to regulation. While interviewees were positive about the way the GOsC communicates with the profession, our survey results suggest that fewer osteopaths in the wider population are positive about GOsC communication and consultation.

Several factors appear relevant to perceptions of the GOsC. Our exploratory factor analysis indicated an aggregate Factor 5 ('Pro-GOsC'; mean response 2.96 where 5 indicates strongly agree and 1 indicates strongly disagree), involving factors linked to the questions: (i) 'The GOsC communicates well with osteopaths'; (ii) 'The GOsC consults well with osteopaths'; (iii) 'I am confident that osteopaths are well regulated by the GOsC'; (iv) 'The GOsC are improving the status of the osteopathic profession'; (v) 'The GOsC registration fees are reasonable'; and (vi) 'Regulation has had a positive effect on how I practise as an osteopath'. We found that osteopaths

working with other osteopaths (mean 3.01 vs 2.89 for those working alone) were significantly more likely to be 'Pro-GOsC' (Factor 5). This raises questions as to whether perceptions of effective GOsC communications were driving an overall positive perception of the GOsC or whether perceptions of good communications were a function of an overall positive perception of the GOsC.

We found two distinct aggregate factors relating to how osteopaths' perceptions of the GOsC were shaped; Factor 8 (Experiential perceptions of the GOsC; mean response 3.73, where 5 indicates strongly agree and 1 strongly disagree) was comprised of factors associated with perceptions of the GOsC being shaped by 'My experiences of the GOsC' and 'The GOsC's communication'; Factor 10 ('Narrative perceptions of the GOsC'; mean response 3.02, where 5 indicates strongly agree and 1 strongly disagree) comprised factors relating to perceptions of the GOsC being based on: 'what I hear from professional colleagues' and 'what I hear about regulation in the news'. We found a significant association (0.164) between time qualified as an osteopath and their perceptions of the GOsC being more affected by 'Experiential perceptions of the GOsC' (Factor 8). Osteopaths who had had a complaint made against them to the GOsC were significantly more likely (mean 3.94 vs 3.71) to be affected by 'Experiential perceptions of the GOsC (Factor 8) perhaps for obvious reasons.

While interview data suggest that longer qualified osteopaths may be more sceptical of the GOsC, our analysis of survey data found no association between length of time qualified as an osteopath and being pro-GOsC (Factor 5 –see below). We did, however, find a significant negative association between length of time qualified as an osteopath and believing 'the OPS reflect what it means to be a good osteopath' and the view that 'Osteopaths should be regulated by the law'. So longer qualified osteopaths are less likely to believe the OPS reflect being a good osteopath or that osteopathy should be regulated by law. Our factor analysis of survey data also indicated a factor (6) relating to 'fear-based compliance with regulation' and there was a negative correlation (-0.74) between this and time qualified as an osteopath, meaning that, more recently qualified osteopaths may be most fearful of regulation.

These findings may be because the GOsC have (as discussed above) recently had more contact with OEIs and OEIs appear to devote considerable effort to talking to osteopathy students about regulation and standards.

In sum, interviews suggested that suspicion of the GOsC and regulation within the osteopathy profession remained, which was largely due to an historical legacy from regulatory problems and antagonistic relations between the GOsC and the osteopathy profession more than a decade ago. However, while more recently qualified osteopaths appeared, from our analysis of survey data, to believe that osteopaths should be regulated by law and that the OPS reflected what it means to be a good osteopath, we found no correlation between our aggregate factor (5) relating to being 'pro-GOsC' and time qualified as an osteopath.

On balance from our survey it appears more osteopaths are positive rather than negative about the GOsC. 44% of respondents to our survey agree 'I am confident that osteopaths are well regulated by the GOsC' (25% disagree; 32% neither agreed nor disagreed). 40% agree 'regulation has a positive effect on how I practise as an osteopath (29% disagreed). 43% agreed 'the GOsC communicates well with osteopaths' (26% disagreed); 36% agreed that 'The GOsC consults well with osteopaths' (29% disagreed). However, only 25% agree 'The GOsC are improving the status of the osteopathic profession' (41% disagreed) and only 24% agreed 'The GOsC registration fees are reasonable' (54% disagreed). So there is room for improving the way in which osteopaths see the GOsC and particularly in terms of the value for money it offers professional registrants.

We note the ways in which perceptions of the GOsC and regulation more generally frame the way osteopaths perceived, react to and comply with OPS. It therefore seems important that osteopaths understand the purpose of osteopathic regulation and standards and believe they are legitimate, in order for osteopaths to comply with them. We also note, however, that many of the osteopaths we interviewed believed that the GOsC was significantly improved in recent years, as a result of greater personal contact, dialogue, communication and engagement with the

profession. As a result more osteopaths understand why and what the GOsC was trying to achieve and viewed osteopathic regulation as legitimate. We will return to the importance of good relations, engagement and robust dialogue between the GOsC and profession later.

A news producer's perception of osteopathic regulation

In our previous research (McGivern and Fischer, 2010; 2012), we have discussed the ways the media shapes various audiences' perceptions of regulation. Given that the development of health professional regulation has been driven by shocking individual cases of clinical malpractice (e.g. GP Harold Shipman murdering patients, medical malpractice at Bristol Royal Infirmary, Alder Hey Hospital and more recently at Mid-Staffordshire NHS Trust), we suggested that the media attention focused on the 'spectacular' rather than more everyday aspects of regulation. The consequent danger is that regulation may be designed to prevent rare but spectacular and high profile regulatory failings, rather than to develop the practices and professionalism of the majority of those professionals that are regulated. We therefore interviewed a news producer, for a national media organisation, about their views of health professional regulation generally and osteopathic regulation more specifically, in order to understand how a story about regulation would be covered.

The news producer described their role as about filtering news stories:

> *"My job is really to assess the stories coming in and work out if they stand up or not… Is it genuinely new? … Is there a vested interest here masquerading itself as the general good? … Is this something our audience would be interested in? … Is it something that is so technical and esoteric that it is not worth passing on to our audience? Or it is not really comprehensible? … Or something very niche… or that would really panic the audience and we might have a responsibility not to report? So those are some of the hoops that stories have to go through." (5.29G)*

The news producer commented about regulation:

> *"Generally, our audience is not interested in regulation. They are interested if a particular nurse or doctor or osteopath or whatever has done something wrong. But the whole mechanics of how the regulators regulate they are not very – understandably – interested in.… There has to be a very clear kind of public interest and something that everyone can grasp – no technical detail and not a sort of niche story…. It is not just [osteopathic regulation], it is regulation generally… I cannot count the number of stories we have turned down from the GMC. The public is not really interested in exactly how they work… We have hardly ever covered Revalidation – just because we think it is not really of that much interest to our audience" (5.29G)*

The producer did recall putting out one story relating to a "shocking individual case":

> *"One issue we have covered a little bit, which sprang from obviously a very, very shocking individual case – and that is changes to language requirements for post - the case of Daniel Ubani. We have covered that … when the GMC and the government have proposed or enacted various changes about language competency in [NHS] staff." (5.29G)*

The producer suggested that stories about osteopathy were unlikely to get into the news, and again only negative developments relating to dangerous osteopaths or osteopathic techniques would be covered, because few of the producer's audience would have visited an osteopath:

> *"I have never, in the 11 years that I have been doing this job, been given a story about osteopathy. I can imagine that if there was some story [where] someone claimed osteopaths were practising without proper qualifications that would be interesting. Because everyone can put themselves in the position of someone who has gone to a bit of a cowboy. Any story of people who suffered harm at the hands of osteopaths… Or if some sort of technique*

that osteopaths used that suddenly became discredited by research evidence, that might be interesting. But they are all rather negative developments, I concede. I can't really think of any positive development that would interest me, partly because people expect things to work and they expect practitioners to be qualified and expect their techniques to work. It is more that perhaps not a huge proportion of our audience will ever have visited an osteopath." (5.29G)

So what we see here is that the new media are, first, unlikely to report on health professional regulation or revalidation, particularly its technical details or how it affects clinicians' day-to-day practises, because the news producer's audience are not interested in the topic.

Second, the producer is unlikely to report on osteopathy per se; because few of the producers' audience have experience of osteopathy. Third, the only circumstances in which there is likely to be a story about osteopathy or osteopathic regulation are where there is a shocking individual case of malpractice, which is likely to representative osteopaths and osteopathic regulation more generally. So rather than providing transparency per se, media transparency appears biased in favour of bad news.

A politician's perception of regulation

A politician we interviewed, with an interest in health professional regulation, commented that clinical regulatory policy was driven less by rational analysis than by governments needing to be seen to 'do something' in response professional scandal:

"Politicians have great difficulty understanding regulation… People talk rationally and think rationally and have plans and Law Commission Bills and Department of Health Bills… But what happens when push comes to shove … is politics… [Regulatory policy is] driven by… the phrase 'something must be

done' and who has got to do something about it – the government! … I don't think the public on the whole think the profession has got to do something about itself… It has got to be some kind of external intervention for the Shipmans of this world…The Law Commission Regulation Bill; what headlines was anybody going to get out of that? You can see somebody in their manifesto say 'Put an end to the scandal in Mid Staffs' but you can't see 'have a bill about sensible regulation'… Politicians are driven by… the papers and by what comes up in their constituency surgeries. And let us be frank… what they can gain from taking this case. What political kudos can I gain? How many more votes? ... The only way you can get media coverage [about health professional regulation is as through]… one bad apple … that is the hook for politicians isn't it? You know because that is what politicians are there for." (10.21G)

This account reflects previous accounts of the development of 'tombstone regulation' (Hood et al., 2004) developed as a 'pavlovian regulatory response' (Hood and Lodge, 2005) and the development of 'spectacular transparency' in reaction to high profile but atypical cases of professional malpractice (McGivern and Fischer, 2010, McGivern and Fischer, 2012).

A regulator's perception of regulation in the media

We discussed media attention with an interviewee at the GOsC, who argued that, while often a distraction, media attention could also help bring about constructive changes to health professional regulation, again using the example of Daniel Ubani:

"I ask myself the question, does the attention of the media improve ... enhance either the quality of regulation or the ability of the regulator to do its job?" I think the answer is that sometimes it does, but often it is a distraction.... it is complicated… There are good examples of where the media involvement in stories has been quite important for the ultimate resolution of

the matters concerned… a good example is the Daniel Ubani case –the German doctor, who killed a patient in the UK, who didn't speak effective English.... The media focus on that… opened up the debate and led to a change in the law, and led to more effective policing of the English language skills of doctors." (5.9G)

So while the media are perhaps unlikely to focus attention on osteopathy and its regulation, if it were to do so, this is likely to be in way that cast the profession in a negative light. However, this could be used in a way to produce more effective regulation.

A member of staff from another health professional regulator commented that the stories that the media were interested in did not reflect the biggest issues in terms of patient safety, which we consider 'benign drifting incompetence':

"The Sun is not interested in the 60% of cases which are simply about whether people have kept up to speed in their practice, which is the real issue... well … the biggest issue is that question of continuing competence... in terms of delivering patient safety… benign drifting incompetence that affects some professionals… We refer to it as 'supervised neglect'… That is not a very sexy story and that is not going end up in the media. But… that is where most harm to patients is being perpetrated, in a way that is probably avoidable if the system worked in a slightly different way." (6.2G)

So might regulation focusing on more prosaic and less high profile cases of malpractice lead to a greater improvement in patient safety outcomes? We asked questions relating to this issue in our survey. 50% of osteopaths agreed 'Regulation is too focused on rare cases of serious malpractice rather than the day-to-day practices of most health professionals' (16% disagreed; 34% neither agreed nor disagreed), suggesting that osteopaths do feel that regulation is overly driven by spectacular rare cases of malpractice. Only 21% said (55% disagreed) that their own 'perceptions of the GOsC' were based upon 'what I hear about regulation in the news'.

Osteopaths' own perceptions of the GOsC were more affected by: 'The GOsC's communications' (73%; only 5% disagreed); 'experience of the GOsC' (65% agreed; 9% disagreed); what they 'hear from professional colleagues' (60% agreed; 16% disagreed), and, to a lesser extent, 'fear about what the GOsC could do to my osteopathic practice' (46% agreed; 31% disagreed). However, a minority said that 'the GOsC communicates well with osteopaths' (43% agreed; 26% disagreed) or 'consults well with osteopaths' (36% agreed; 29% disagreed).

Summary

In this section we first examined osteopaths' perceptions of the GOsC and regulation. We then briefly looked at the way clinical osteopathy and regulation were perceived and constructed by the news media and politicians.

Overall, osteopaths are more positive than negative about the GOsC. However a number of osteopathic interviewees remained suspicious of the GOsC and osteopathic regulation after historical difficulties and antagonism between the regulator and the profession more than a decade ago. Interviewees who had contact with the GOsC commented on how much the regulator had improved in recent years, particularly because of greater personal engagement between the GOsC and the osteopathy profession. Our survey data suggests that more recently qualified osteopaths are more likely to believe that osteopaths should be regulated by law and that the OPS reflected good osteopathic practice. However we found no association between length of time qualified as an osteopath and our overall 'Pro-GOsC' factor. We suggest that overall perceptions of the GOsC and the legitimacy of osteopathic regulation frame the way osteopaths see the OPS and affect compliance

We interviewed a new producer and a politician about the way the media and politicians perceived generic health professional regulation and osteopathic regulation. What was clear from these interviews was that they were more affected by atypical but high profile cases of 'one bad apple' within professions than by the

day-to-day practice of most professionals. Thus regulation is likely to be developed more in response to rare case of serious malpractice than by a detailed understanding of how regulation affects the majority of professionals. Our survey data suggests that osteopaths are less likely to be affected by media stories about regulation than their day-to-day experience of regulators, their communication and stories about regulators circulating within the profession. A regulator talked about how media stories about malpractice were often 'a distraction' but could be helpful in bringing about improvements to health professional regulation too. It may therefore be incumbent upon regulators to interpret and implement new regulation in a way that is effective in practice

6. Experiences and perceptions of Fitness to Practise hearings

In this section we discuss patients' and osteopaths' attitudes towards and experiences of complaints and Fitness to Practise (FtP) hearings. We begin by discussing the GOsC's complaints procedure and FtP process. We then discuss the findings from our survey in relation to complaints and FtP. Next, we describe the views and experiences of three patients we interviewed, one who made a complaint that was taken to a FtP hearing, and two osteopaths we interviewed who had been subjects to FtP hearings. Finally, we discuss the ways in which other osteopaths were affected by indirect experiences of and stories about such hearings.

The regulatory context of FtP hearings

The GOsC has a legal duty to set the standards of practice that are expected of osteopaths, to protect the public and maintain public confidence in the profession and the osteopaths it regulates. By FtP, GOsC means that osteopaths should have the necessary 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. The guidelines for the safe and competent practice of osteopathy are set out in the OPS.[8]

When the GOsC receives a complaint about an osteopath it has a legal duty to investigate it. First, an independent osteopath will study the complaint to make sure it is something GOsC can deal with. An allegation may not amount to a breach of professional standards, because they are not relevant to the osteopath's work, or because there is unlikely to be sufficient evidence to support the complaint.

Once GOsC agree to investigate a complaint, it will usually contact the osteopath the complaint is about, send them the details of the complaint, ask for a response and might ask for information from other people as part of the investigation.

[8] http://www.osteopathy.org.uk/information/complaints/fitness-to-practise/

GOsC will then ask its Investigating Committee to look at the information within four months of a complaint being received. This committee is made up of osteopaths and lay members (non-osteopaths) and chaired by a lay person. The committee will decide whether all the information supports the complaint and whether the allegations would amount to: unacceptable professional conduct; professional incompetence; a criminal conviction in the UK that is relevant to the work of the osteopath; or a medical condition that seriously affects the osteopath's ability to practise. If the committee finds that there is a case to answer, the GOsC will arrange a public hearing and instruct its solicitors to prepare the case against the osteopath.

If the complaint concerns an osteopath's professional conduct or competence, or a criminal conviction that is relevant to his/her work, it will be heard by the Professional Conduct Committee. GOsC aims to hold the hearing within nine months of it being referred by the Investigating Committee.

Complaints about an osteopath's mental or physical health are passed to the Health Committee, which can look at cases without having a hearing and meets in private because it has to consider an osteopath's medical condition. If there are serious worries about the osteopath's health, the committee may require the osteopath to meet certain conditions or can prevent the osteopath from working for a set time by suspending their registration[9].

Survey results relating to FtP

In our survey, 43% agreed (28% disagreed, 29% neither agreed nor disagreed) that they 'fully understand the GOsC process for handling complaints made against osteopaths by patients and the public'. In the 2012 GOsC Osteopaths' Opinion Survey (where there was not a 'neither agree nor disagree' option'), 48% agreed and 51% disagreed with the same question. So while the absolute percentage of osteopaths agreeing with this question is lower than in 2012, the proportion

[9] http://www.osteopathy.org.uk/information/complaints/our-complaint-process/

agreeing is higher in the 2014 survey, suggestion osteopaths understanding of the GOsC complaints process has improved.

23% of osteopaths agreed (24% disagreed; 53% neither agreed nor disagreed) they were 'confident that the GOsC's disciplinary procedures produce fair outcomes'. In the 2012 GOsC Osteopaths' Opinion Survey, 27% agreed and 60% disagreed with this statement. Again, so while the absolute percentage of osteopaths agreeing the GOsC's 'disciplinary procedures are fair' are lower slightly in 2014, the proportion is higher than 2012. Given the relatively low numbers of complaints about osteopaths, it is perhaps unsurprising that there were relatively low numbers of osteopaths who understood or were able to agree that GOsC's disciplinary procedures were fair. However we found that osteopaths who had had a complaint made against them to the GOsC were significantly *less* confident that 'the GOsC's disciplinary procedures produce fair outcomes (mean 2.72 versus 2.96 for those who had not). We will discuss below the ways in which osteopaths perceptions of disciplinary procedures may be shaped by stories about these procedures circulating within the osteopathy profession, however we will first explore patients' views and experiences of this issue.

Patients' perceptions of osteopathic regulation

In the section below we describe the experience and view of regulation of three patients we interviewed; first two patients who had positive experiences of osteopathy and then a patient who made a complaint to GOsC about an osteopath who treated them.

Patient A

Patient A "had never heard of osteopaths" before they were referred to an osteopathic clinic by their GP practice to address severe ongoing pain. Their experience of osteopathy was positive. Patient A noted:

"I am really happy with the treatment… because the GP and the hospital that saw me, they couldn't actually find this cause. But with the osteopath's treatment they found it… the reason for my ongoing pain, all the years, they said it was muscular skeletal." (4.21G)

We see that the patient's first contact their GP and was then referred to a NHS hospital which was unable to address the problem. It was then an osteopath who was able to find the cause of the patient's pain. Asked about what they would like from osteopathic regulation as a patient, Patient A noted:

"On the internet site they have got a list of osteopaths who are registered to carry out treatment… So if anyone wants to check they can go in and check that… if I was going to a private osteopath I would definitely go onto the internet site and search… for the person who is going to do my treatment… all the guidance is there, all the information is there. There is a contact number, and there is an email address, whereby the patient can get in contact with GOsC or other bodies, to find out any other information that they are not sure of, or any queries that they want to relate. There is also the complaints procedure, where if somebody is unhappy with the treatment they can actually go and complain about that." (4.21G)

So easy access to the GOsC register of osteopaths and information about how they might complain appeared most important for this patient.

Patient B

Patient B also told a story about receiving ineffective treatment for their problem from the NHS and then being helped by an osteopath. Patient B went to see their GP following an injury and described the GP as "absolutely hopeless", who simply suggested Patient B "just go and buy some Paracetamol and don't bother me". Patient B then visited an osteopath and their experience by contrast "was positive in

that it helped" and that their osteopath got "a lot of information out of me" which enabled them to find the cause of Patient B's problem.

Asked about what Patient B wanted from osteopathic regulation, they noted:

> *"I think any guidance that people can be given about what an osteopath is, who they are regulated by, what they can and can't do, and what they should and shouldn't be doing. And what to expect when you go and see one, is extremely useful." (4.22G1)*

Asked about how the regulator should deal with problem osteopaths, Patient B commented:

> *"I have never really come up against something that I felt wasn't quite right… I don't know, that is difficult to answer." (4.22G1)*

From these two, admittedly limited, accounts we see that patients appear to have little understanding of osteopathy, OPS or osteopathic regulation. They appear to judge osteopaths on the basis that they are able to resolve the clinical conditions patients came to see them with and behave and communicate in a professional manner, which both did and resolved problems the NHS had been unable to. What these patients want from GOsC is that it displays information on its website about osteopathy and what to do should patients want to make a complaint, and enable patients to find a registered osteopath on the GOsC website. These patients felt unable to comment on what they might want if they made a complaint about an osteopath.

Patient C

We next briefly describe the experience of Patient C, who made a complaint to the GOsC about an osteopath, which was taken to a FtP hearing.

Patient C received treatment from Osteopath X, whom Patient C described as a "*technically… very good*" osteopath, which made patient C "*feel good physically*" and they "*got on very well with Osteopath X*" who was "very friendly". Patient C described how the boundaries between osteopath X and patient C became blurred following an invitation to the cinema: *"Osteopath X… said they had a spare ticket for the cinema... we knew each other very well by this stage… chatting like old friends… So, we went to this performance and… several more." (4.16G1)*

Patient C then described how Osteopath X distanced themselves from Patient C: *"Soon after that… I was going for my osteopathic sessions, Osteopath X started becoming a bit remote and a bit uncommunicative and almost hostile."* Patient C then received a phone message saying that it was no longer *"suitable for you to continue receiving osteopathic treatment" (4.16G1)* without further explanation. Patient C discussed a sense of confusion they felt about the boundaries between themselves and Osteopath X and attempted to contact Osteopath X to resolve this issue without a response. Patient C then decided to make a complaint about Osteopath X because they:

> *"Couldn't get a communication with the clinic and I couldn't get any direct communication with Osteopath X at all, since that day. So I made an official complaint [to GOsC], not because Osteopath X had invited me to go to the cinema… I didn't have an issue with that, but I had an issue with the fact that I had been dismissed without any clear explanation." (4.16G1)*

However Patient C felt that the case brought against Osteopath X was not what Patient C had complained about:

> *"When I looked again at the case they [GOsC] were bringing against Osteopath X… it was not really what I was complaining about…. I was complaining about… the lack of communication latterly… and unpleasant behaviour. The charge brought against Osteopath X [by GOsC] was that*

Osteopath X had acted… in a way that could have been interpreted as an invitation to a closer relationship, which was not my complaint." (4.16G1)

Patient C described the disciplinary hearing as "*a bit traumatic for all concerned*" and how:

"The hearing was thrown out as no case to answer. So the whole thing was… inconsequential ... it wasn't resolved. I was very happy with everybody there [at the GOsC] … they were excellent… But the detailed report of their findings – it had so many holes in it, I thought "gosh if this was the way a legal process happens… then I haven't got much faith in the way of the law." (4.16G1)

Instead, Patient C commented that they would have preferred mediation with Osteopath X rather than to have gone through a disciplinary hearing:

"I wished that the GOsC had some sort of mediation… it would have been better for all concerned, and it would certainly have been less upsetting and less traumatic for me, and I imagine that would have been much better for Osteopath X… [The hearing left] that feeling of sort of [being] unresolved… polarised… I eventually realised Osteopath X had been told… they mustn't contact me under any circumstances." (4.16G1)

Patient C also suggested that osteopaths needed better training in "dealing with people" and how a mediation meeting would have made a formal complaint unnecessary:

"I was surprised that in their [osteopaths'] training… they are not given more training in… dealing with people... there was no particular reason why it needed to go to the General Osteopathic Council if it had been handled properly". (4.16G1)

Despite Patient C's complaint about Osteopath X's behaviours and communication, they commented: *"I would still recommend Osteopath X as an osteopath."*

This case study, illustrates the importance of maintaining clear professional boundaries between osteopaths and patients. Osteopath X's invitation was perhaps motivated by friendship and kindness towards a patient but it was interpreted ambiguously leading to consequent problems.

The case also highlights the potential benefit of mediation and communication between patients and osteopaths, and the need for better communication mechanisms and training for the osteopath involved in this case, which might have prevented a complaint being made to the GOsC, which ultimately was not what Patient C wanted, who felt their actual grievance had not been addressed, and Osteopath X, who was found to have no case to answer.

In this case, it would appear that the formal complaints process and consequent Fitness to Practice hearing were not perceived have produced a satisfactory outcome for Patient C and was "traumatic" for both Patient C and Osteopath X. The complaints process was not perceived to reflect the actual issues Patient C wanted to be addressed. Patient C suggests that informal mediation between patient and osteopath may have may have been more able to address the issues Patient C complained about. While our discussion of a single case of a patient complaint does not allow us to make claims for wider generalisibility, patient concerns relating to the complexity and time involved in the process reflect more extensive earlier research (Leach et al., 2011) on patients experiences of making complaints about osteopaths.

The perspectives of osteopaths subject to FtP hearings

We next describe the experiences of two osteopaths we interviewed who had been subject to FtP hearings. Again, because of this limited number of interviews, the

extent to which it is possible to generalise from the cases below is limited. However the cases provide some interesting insights nonetheless in an under-explored field.

Osteopath Y

A couple of osteopaths had raised "concerns" to GOsC about the way Osteopath Y had been promoting their practice Osteopath Y was consequently *"investigated for various misdemeanours… counts of gross professional misconduct and bringing the profession into disrepute"*. The investigation lasted over 12 months, and Osteopath Y spent "thousands of pounds" on lawyers before *"the investigatory committee found there was no case to answer. And then my hell was over."* (5.21O)

Osteopath Y expressed concerns that *"osteopath regulations are so rigid that actually there is no place for being a human being. You have to be a robot which makes you ineffective practitioners"* and commented:

> *"I have shadowed several osteopaths and top physios and... no one can work within these regulations… it is not flexible enough: it doesn't mean that you are a bad osteopath, because I didn't offer a patient a chaperone or I didn't explain x, y and z to every patient... I am not going to explain to my patient that there is a risk that after massage they could have x, y, z. If I think the patient might be sore for a while, I would say: "You might be sore for a while but that is one of the risks of the treatment". It is just a worry … the General Osteopathic Council [will] investigate osteopaths who they perceive as not following regulation to the letter of the regulation…. it restricts osteopaths… every single osteopath knows that they are not following the letter of the code with every single treatment. So we are all guilty every single day of our professional lives." (5.21O)*

Osteopath Y describes the FtP process as like "hell" and at the end of it, rather than changing the way they practise as an osteopath to comply with regulation, Osteopath Y simply perceived that osteopathic regulation is too rigid, does not

reflect the way osteopathy is practised and so consequently all osteopaths are "guilty every single day". Osteopath Y perceived the FtP process as more punitive than developmental or remedial. Osteopath Y does not appear to have changed how they practise after the experience but to have become more cynical about osteopathic regulation. Hence, while the GOsC has a statutory duty to investigate complaints about osteopaths' FtP, there is there a risk that some osteopaths may emerge from FtP processes *less* professionally engaged and consequently at risk of future malpractice.

Osteopath Z

Osteopath Z is an experienced osteopath who is in favour of osteopath regulation in principle, noting:

> *"As far as the public are concerned I think they want to know that the person that they are… trusting their back to is well qualified and is able to do the job professionally and that is the way I saw the regulation… a kite-mark … I am in favour of it [regulation] in principle, it is a question of how heavy handed it is." (5.15G)*

A complaint was made to the GOsC about Osteopath Z's osteopathic practice by a patient. Osteopath Z initially *"felt it was a little bit unfair that... [GOsC] didn't encourage the patient to sort it out with me first."* So this osteopath believes that complaints are best addressed informally, between osteopath and patient, and should only become an issue for the regulator if they cannot be resolved by other means.

Osteopath Z described the FtP hearing as *"an adversarial process"* and complained that the hearing did not examine *"the nature of my practice but they looked at my notes. And then they ... decided that the notes weren't of sufficient standard"*. Osteopath Z concluded:

> *"The things that the patient complained about weren't found. In other words they found in my favour. The only thing they found against me was the notes." (5.15G)*

Osteopath Z was surprised their *"notes were seen to be inadequate"* and *"wondered what the general standard is. If you don't have an average then it is difficult to judge an individual against an average."* Osteopath Z suggested that they *"wouldn't be surprised if 75% of people"* were taking sub-standard notes *because "everybody has a different way of taking notes"* and that:

> *"If the General Osteopathic Council are going to impose a standard, then they should say what that standard is and teach that standard in the [osteopathic] schools… it doesn't even seem within one school that the note taking seems to reflect one school or another." (5.15G)*

Osteopath Z went on*:*

> *"I fully accept that what they [GOsC] are trying to do in raising standards, and I am fully on board with that… [but GOsC] were a bit heavy handed. I think they tried to impose regulation and not carry the membership with them… it is important to engage… [GOsC are] trying to encourage sort of medical standards which aren't necessarily appropriate for osteopathy." (5.15G)*

Here it seems important that the regulator and osteopath engage to ensure that the standards imposed on osteopaths reflect osteopaths' practice and make sense to them, through a process of professional reflection and dialogue, in order to avoid losing profession engagement and a consequent potential decoupling of practice from the way it is presented.

Concluding on their experience of the FtP hearing, Osteopath Z commented:

"Unless I have committed a criminal act, which is fair enough, and I would expect to be punished for it… a process like that should be a learning process and it didn't come across like that – it was just adversarial."

Again, the osteopath implies that there should be levels of complaint, with the least serious complaints being treated more developmentally and the more serious in more legalistic terms. Asked whether the experience of the FtP hearing had changed the way osteopath Z practised, they noted:

"It is a shame… I had something to offer [the osteopathy profession] … and I would have offered it but now really I don't feel like doing it… my notes are perhaps a little bit more particular. But it hasn't changed the way I practice." (5.15G)

In this third case, Osteopath Z describes the FtP hearing in a way that suggested that it did little to improve their practice. Rather than viewing their practice as inadequate, and accordingly changing or improving it, Osteopath Z believed that their experience of the FtP hearing highlighted the ambiguous nature of standards (here relating to note keeping, reflecting the discussion in the section on views of standard). Furthermore, Osteopath Z described no longer feeling like contributing towards the osteopathic profession. The GOsC has a statutory responsibility to investigate complaints about osteopaths' FtP. However, here again, the osteopaths' account suggests that rather than having a remedial or developmental effect on their practice or professionalism, the FtP process led to professional disengagement, which research[10] suggests may put professionals at risk of future malpractice.

Clearly our research is based upon a very limited number of interviews, only two osteopaths subject to FtP cases and one patient who had made a complaint which went to a FtP hearing. However, as noted earlier, our survey data found that osteopaths who had been subject to a complaint taken to the GOsC were

[10] http://www.hpc-uk.org/assets/documents/10004605EducationUpdate-Issue16-May2014-e.pdf see page 6

significantly less likely to be 'confident that the GOsC disciplinary processes produce fair outcomes' (with a mean response of 2.72 for those who had been subject to a complaint compared to 2.96 for those who had not, where 1 is strongly disagree and 5 strongly agree), which was the only significant demographic variable affecting response to this question. Further research among these two groups, to discover more about patients' and osteopaths' experiences of FtP is necessary to test our findings.

Other osteopaths' perceptions of colleagues who had been subject to FtP hearing

Fitness to Practice hearings did not only affect osteopaths who were subject to investigations, they also had knock-on implications for their colleagues. For example, we interviewed an osteopath who had sat in on a colleague's FtP hearings, who commented:

> *"Having gone to a hearing to support a colleague I would be horrified [to be subject to a complaint]. I couldn't believe what an awful situation it was… I found it quite galling that the complaint got as far as it did – to the Fitness to Practice Committee. I think it should have been got rid of in a much more constructive way long before then. Myself and several colleagues who know this individual, we were all quite angry and appalled, because we knew [the osteopath subject to the FtP hearing] as a good clinician and a very safe practitioner. And just the whole process, the way it was very long and drawn out. The final grounds that they caught [my osteopathic colleague] on, was note keeping. But…. there is nothing to say that you have to meet those standards in 'x' number of your notes... There is no guideline on this. So I said to this osteopath's barrister – if it was a case of note keeping issues you'd have every one of us up in front of the Fitness to Practice Committee. Notes may vary if you are having a busy day. You might write less than you would on a less busy day… [my osteopath colleague] was caught over note keeping and we felt … they [the FtP Hearing] had got so far and so there had to be*

something to make it all justified: whereas actually it was just nonsense. The Fitness to Practice system is one area that I have real reservations about. And just being in the room as a witness was... it was a scary process. Not a good experience. It made me a lot more careful with my notes. It made me quite – fearful isn't the right word – but the fact that… things could escalate quite disproportionately to being in that situation, was really quite concerning." (4.29G1)

So having attended the FtP hearing, the osteopath had become more careful in their note-keeping. However, like Osteopath Z, they perceived that the lack of clarity relating to standards was problematic (vague standards making it difficult for osteopaths to know exactly what to do, as also discussed in the section on standards) rather than the practice of the osteopath subject to the FtP hearing, potentially fuelling disengagement from and cynicism towards the regulator.

In previous research on doctors, psychotherapists and counsellors (McGivern and Fischer, 2010; 2012) we have discussed the ways in which professionals' perceptions of regulation are shaped by stories they hear from colleagues. In our survey, 60% of osteopaths agreed (16% disagreed) that their perceptions of GOsC were based in 'what I hear from professional colleagues'. Osteopaths also talked about the way perceptions of FtP hearings circulated within the osteopathy profession, stemming from stories about the experiences of those involved in FtP cases. One osteopath noted:

"While there are only 10 or 15 cases a year, those 10 to 15 people talk to other osteopaths, who talk to other osteopaths and the sort of maltreatment news spreads like wildfire – or the perception of maltreatment." (3.7O)

"My colleague had… a clinical complaint, but the GOsC took this particular person to task for not offering his patient a towel... If somebody complains against you, they don't just investigate the complaint; they investigate you as an osteopath… They [GOsC] spend an awful lot of money on things, they are

going to try and find something – it is a bit like the tax man coming round and wanting to find something wrong… From having spoken to colleagues... the standard is an 'ideal osteopath' not an osteopath in normal daily practice… And you should be held to that standard [for normal daily practice]… The world isn't perfect... osteopaths aren't perfect. Most osteopaths I know are trying their best. Yes there are some bad eggs, from what you hear, but most people that I have come into contact with are incredibly caring, incredibly passionate, really want to be doing their best… ... it feels like there is a real separation between the regulators and the osteopaths." (6.6G2)

Again reflecting previous research (McGivern and Fischer, 2010; 2012), some osteopaths expressed fear about being involved in a FtP hearing and worried that, based on anecdotes, osteopaths were seen as *"guilty until proven innocent"* and that GOsC would *"hunt until they find something to get you on"* rather than encourage best practice:

"I would feel it is guilty until proven innocent… I would feel that the GOsC would take the patient's word over mine… I would be really, really scared... I just get the impression, and mostly anecdotally from colleagues, that if they [GOsC] don't get you on one thing they will hunt and hunt until they find something to get you on…. If they don't get you on the main complaint they will find something. They are seeking to look for faults… I don't think that they necessarily want to encourage best practice in you." (06.06Z)

Another osteopath expressed fear that a FtP hearing would be *"like facing the Spanish Inquisition"* with this fear was fuelled by what was perceived to be the punitive tone in which regulation documentation was written:

"You fear that... it [a FtP hearing] will be like facing the Spanish Inquisition… even though I think of myself as a very rational person … we fear that people will not understand ... the way in which [osteopathy works] …. The new regulations are that everything goes to a hearing…. everything seems to be

linked with punitive action.. The first thing I saw on the re-regulation documents, was that... 'Doing this … falsely, will lead to criminal prosecution' in big red letters across the front… I think a small handful, on the fingers of one hand, of people who falsely tried to [submit documentation]. But it frightened several thousand people." (6.6G)

Thus, due to the severity of the FtP process, some osteopaths believed it made sense to worry about patient complaints *"even if you are totally innocent"*, as the following osteopath notes:

"The closest I got I think was a patient… suggesting that they were going to make a complaint… that she had a very bad reaction to my treatment… The person concerned had some mental issues and had been trying to get money off practitioners she had visited… [My reaction was] panic! And that is when you probably start to see the GOsC in a slightly different light… You start to get concerned about patient complaints… I see the complaints process as a fairly severe one… I think there is that sort of fairly rational concern, even if you are totally innocent." (04.29G2)

As has been discussed in previous research (McGivern and Fischer, 2012) and the Francis Inquiry, in a regulatory context perceived to be 'punitive' and 'inquisition like' (with such perceptions based on stories circulating within professions) professionals are more likely to present themselves and their practice in a way to avoid suspicion. Professionals may cover up rather than trying to improve poor practice. In addition, such context may be perceived to lack legitimacy, so professionals may feel justified in de-coupling from regulation.

Another osteopath described a further case where a complaint led to a FtP hearing and an osteopath being admonished even though "nothing horrible happened", the patient was happy and made no complaint themselves, which fed a sense of distrust in osteopathic regulation:

"If a complaint is lodged the GOsC has to follow it through … even if the complainant withdrew their complaint. There was a really high-profile one where… an osteopath attended a mum in labour. The mum wanted them there. The osteopath wanted to be there. Nothing horrible happened. But someone within the nursing and midwifery team took offence to the fact that an osteopath was present and raised a complaint. And when the patient and the patient's family came forward and said no, no, no, there is no complaint, we were happy. The GOsC wasn't allowed to say 'well that is OK then'. And that osteopath was taken thorough a very lengthy process of investigation … it didn't end up very well because it was found that actually we don't have the right to be present that the birth… [Such high profile stories] feed that notion of mistrust – that they [GOsC] are out to get you." (5.6G1)

One problem is that the GOsC's ability to adapt the way it deals with complaints is restricted by legislation. An interviewee from GOsC noted:

"The problem that we have is that our legislation says that if somebody raises a concern with us we have to investigate it... [whereas] other regulators have threshold criteria, … which basically means that you can head some stuff off at the pass, and say this is really not for the National Regulator." (9.5G)

So, unlike other regulators such as the GMC, which has more scope within its legislation to address complaints informally and avoid formal disciplinary hearings if that can lead to an effective outcome, the GOsC is legally bound to investigate complaints made about osteopaths. Yet osteopaths' fear about being caught up in a FtP hearing for minor offences may lead them to disengage from regulation and less openly discuss and hence address potentially sub-standard practice or professionalism.

One osteopath proposed that a complaints system could be developed around:

> *"A system of 'flags'… People accused of touching patient's [inappropriately]… or if the osteopath hurts the patient, then patient complaints about clinical errors are 'danger, red flag' and must be investigated. Everything else… minor offences… here is a yellow card, here is a warning, just be careful … but … we are not going to investigate you." (5.21 O)*

Several interviewees used the language of 'red flags' and 'yellow cards' when discussing osteopathic regulation. While in clinical terms 'red flags' and 'yellow flags' have specific meanings, which might not reflect the precise intent of osteopathic regulation (in particular, in clinical terms 'yellow flags' indicate psychosocial issues)[11], such terminology may be useful for the purposes of developing more developmental approaches to regulation and dealing with complaints.

An interviewee from the British Osteopathic Association suggested that encouraging patients to use its mediation service might help prevent less serious complaints escalating into formal FtP hearings:

> *"Other health regulators … have an in-house complaints section, which gets rid of a lot of [inappropriate] calls … [the British Osteopathic Association has] a mediation service, which actually does the same sort of thing. If your issue with an osteopath is about whether… were slightly late in their appointments… don't call GOsC… encourage your clients, if they are at all unhappy, to phone… the BOA mediation service first. Because if they phone GOsC the chances are that you are going to end up in [GOsC hearing where]… over 90% get let off…. [but] … costs a massive amount of money. The worst bit is … you are sitting as an osteopath with this Sword of Damocles hanging over your head, for typically 18 to 24 months." (7.3O)*

In sum, stories about complaints and FtP hearings shape the ways in which osteopaths think about and react to regulation. Of osteopaths responding to our

[11] http://www.physio-pedia.com/The_Flag_System

survey, 60% agreed (only 16% disagreed) that their perceptions of regulation were affected by 'What I hear from professional colleagues'. As noted earlier, exploratory factor analysis indicates a two dimensional construct for Narrative perceptions of the GOsC' (Factor 10), involving two factors 'what I hear from professional colleagues' and 'what I hear about regulation in the news'. Those who have had a complaint made against them that did not go to the GOsC are significantly more likely to base their perceptions of the GOsC on 'narrative perceptions of the GOsC' (Factor 10). While we found a positive association between time qualified and 'experiential perceptions of the GOsC' (Factor 8), we found no association between time qualified as an osteopath and 'narrative perceptions of the GOsC' (Factor 10). There was, however, a significant negative association (-0.074) between 'fear based compliance with regulation' (Factor 6) and time qualified osteopaths (i.e. more recent osteopaths tend to take a more defensive attitude towards complying with regulation).

A more developmental approach to regulation and FtP or encouraging more use of mediation services may help assuage osteopaths' anxieties about engaging with regulatory processes.

Summary

In this section we have examined experiences and perceptions of FtP hearings, among patients, including a patient who made a complaint that went to a FtP hearing, two osteopaths who had been subject to FtP hearings, and osteopaths who had witnessed or heard about colleagues subject to FtP hearings. The patient complained that the FtP hearing had been 'traumatic for all involved' and that, while fair and well managed, the case the osteopath faced was not the issue the patient had originally complained about.

Similarly both osteopaths found the FtP processes upsetting and felt that the cases against them were not about serious malpractice, should never have been made and could have been resolved through informal processes. Moreover their experiences in

FtP hearings do not appear to have led these osteopaths to improve their practice, rather to disengage from their profession, reflecting research (Papadakis et al., 2008, Bismark et al., 2013)[12] suggesting that clinical professionals subject to complaints are significantly more likely to have received subsequent complaints.

The relatively small number of patients and osteopaths we interviewed limits the extent to which it is possible to generalise from our findings. However our survey and interview-based findings broadly reflect previous GOsC-commissioned research, conducted by Moulton Hall Ltd on patients and registrants' experiences of complaints (see Annex B to Item 4 of the report to the Osteopathic Practice Committee, 2 October 2014). Moulton Hall found that both patients making complaints and osteopaths subject to complaints were generally happy with the way the GOsC facilitated the process and viewed the process as fair. Yet both patients making complaints and osteopaths subject to complaints felt the process lasted too long and could have been resolved informally, without the need for a formal hearing. In addition, the outcomes of these hearings were often not what the participants would have wanted and were perceived to become decoupled from original complaints, and that complaints might have been better resolved informally. Similarly, other research (Leach et al., 2011) indicated that patients found making complaints about osteopaths too long and complex, and that patients felt inadequately supported through the process.

Interviewees suggested that negative stories about FtP hearings affected how other osteopaths think about osteopathic regulation, leading them to worry about being subject to a FtP hearing regardless of the quality of their osteopathic practice or professionalism. This may lead osteopaths to try to hide and cover up issues where they are worried about veering into malpractice. 60% of osteopaths in our survey agree that their perceptions of the GOsC were affected by what they hear from professional colleagues and only 23% of respondents to our survey agreed that they were 'confident that the GOsC's disciplinary procedures produce fair outcomes' (53%

[12] http://www.gmc-uk.org/SOMEP_2014.pdf_58053580.pdf and http://www.gmc-uk.org/SOMEP_2013_web.pdf_53703867.pdf (see p87)

neither agreed nor disagreed). Osteopaths who had been through a disciplinary hearing were significantly less likely to agree. We suggest, therefore, that informal professional and developmental processes which can proactively deal with less serious concerns about osteopaths' practice are important, as we will discuss in the following section.

7. Dealing with problems, near misses and complaints in practice

In this section we examine the ways osteopaths described how they dealt with any problems, worries and near misses in their own practices. We also examine how they addressed and/or reported (or not) concerns about osteopathic colleagues' practices or professionalism.

Many osteopaths we spoke to readily recalled examples of mistakes, near-misses or moments of crisis (which we discuss below), which caused them to anxiously reflect on their practice, review their notes, and consider changes to their practice. This often prompted conversations with colleagues to discuss the issues, and sometimes their training institutes. Following such incidents, several osteopaths went on to take further training, read more about what may have gone wrong and developed safer techniques. Whereas some reacted by panicking and worrying about the repercussions to themselves and their careers, the accounts we heard generally suggested that osteopaths dealt with problems and near misses in a developmental way. Some osteopaths likened such experiences to a traumatic 'baptism of fire' in which they were confronted by the potential risks of certain osteopathic practices to patients, as well as the risks of such practices to themselves and their own careers. They tended to seek out supportive conversations at times of such mistakes to work out 'what the hell have I done'. Thus experience and professional socialisation were important elements in the ways osteopaths learned to become better osteopaths.

At such times, osteopaths described seeking guidance from colleagues, new information from research, reviewing their notes, reflecting on their practice, and taking further development courses. However few osteopaths described seeking advice or guidance from the regulator, which tended not to be considered as an option at such times for reasons we will discuss. As one osteopath told us, the potential regulatory response following an incident puts the regulator 'in a completely different light', suggesting a policing/prosecuting function rather than professional advice or support.

Dealing with problems and near misses in osteopaths' own practices

The section below describes a number of osteopaths' experiences of problems and near misses in their own osteopathic practice, including how they felt about, reacted to and learnt from the experience and consequently changed their practice. One osteopath described:

> *"Someone passed out after I did a neck manipulation. Yes I felt shitty. I wondered what I hadn't done. I looked through my notes … He was taken to hospital and nothing was found in him. No damage… Since then… it did make me much more aware of… potential dangers and therefore I found different techniques for doing the same thing, which are much less intrusive… I went and did some more courses on the different techniques that I found just as effective as the bone-setting techniques that the [OEI] taught me. And listen to more of what people were saying outside. You know it makes you communicate more with your colleagues. (06.24G)*

So here, without the involvement of the GOsC or other parties, the osteopath appears to have learned from the incident, taken further training and changed their clinical practice following the incident, as well as become more aware of potential dangers associated with osteopathy and the importance of communicating with colleagues. Another osteopath described another incident where they worried about having harmed a patient, which prompted them to communicate with colleagues and learn from the experience:

> *"It was literally a week after I had qualified… I was working near his [patient's] neck and I thought this neck is really tight I am just going to give it a bit of a crack. So I did that and he went grey and then we went white... I could feel my bowels about to let go, thinking that is it, my career is down the pan and I have killed a patient! … That was a bit of a baptism of fire, yes. You just think: I am just going to get struck off immediately? … that really freaked*

me out. I talked to a colleague… She was very sweet and said: "Well you know you learn something from it". And I did." (04.16 Z1)

Thus we see in the above narrative the emotional component to formative osteopathic learning and reflection. A third osteopath describes a number of instances where they had worried about their practice:

"I manipulated his [a patient's] foot and without warning him he passed out. And I went into a cold sweat and I couldn't find a pulse. And thought: oh dear, what do I do now? And he came to and said, "Sorry I should have told you, I do that whenever anybody hurts me!"… There was a lady who had headaches, and I was going to manipulate her neck. Something prompted me to look into her eyes… I didn't like what I saw, but I didn't know what it was but I said: "Look I am not going to manipulate your neck, go and get your eyes checked." And she had a detached retina and I would have made it much worse if I had used any force on her neck… [With another patient] I used too much force and I sprained a rib… She knew I had done it wrong and I knew I had done it wrong. And I said I will fix it and I won't charge you… and she remains a patient." (4.9G)

Another osteopath described a more "terrifying" incident involving a patient who suffered heart failure following an osteopathic treatment:

"There is one occasion… which still slightly terrifies me... There was a … patient … who had Downs Syndrome but also had a heart problem… The first time I treated him I didn't quite think through what was going on… I did a treatment that worked on other things, because it felt like what the body needed in that moment, to help to open the lungs. And that completely undermined… the band around the pulmonary artery was doing. And he went into heart failure… over the next few days and spent a couple of weeks in hospital, before coming out… This was a side effect that… had never occurred to me before… A few years ago I did the classical osteopathy course. And it

wasn't until I did that, that I really understood what had actually happened with this patient... I was very, very lucky. The father of this patient [and I]… had some very frank discussions about… that treatment probably had been a contributing factor in that episode; it wasn't the first episode of heart failure ... I certainly learnt from it.... I was quite open with them [the patient's parents], because I felt that was absolutely important." (6.4O)

This case illustrates the potential dangers associated with osteopathic treatment of certain patients, despite osteopathy being a relatively low risk practice. The osteopath appears to have learned to think through the patient's symptoms, as well as doing what "felt like what the body needed in that moment" as a result of this episode and their candid discussion with the patient's parents appears to have been constructive and avoided a complaint being made. However, patient safety is not simply about "thinking through" patient symptoms and treatments. Another osteopath described how the unusual way their clients' body felt intuitively alerted them to a serious potential problem that might have arisen had they given the patient, with "straight-forward" symptoms, the treatment they requested. The osteopath described how the patient presented in a straight-forward way without any 'red flags' alerting the osteopath to potential problems:

"A particular patient… was referred through an insurer who came with fairly straight-forward back symptoms. He had seen another practitioner in a different discipline and really felt his back wanted a 'good going over'... There was nothing obvious in his history that would have raised a concern or a red flag." (4.29G1)

The osteopath described how when they started treating the patient their back felt abnormal, different to any other patients they had treated:

"His back felt so odd in its stiffness that I wouldn't have thought of manipulating it. It just didn't feel right to do that. And I think it is very hard to explain that on an academic or research basis. But there is obviously

something in the tissues… that is the beauty of doing hands-on treatment – the fact that you do get to know what is acceptable to try with different treatments and what isn't." (4.29G1)

The osteopath described how, on an intuitive basis developed through experience of osteopathic practice, they decided to refer the patient to their GP rather than continue with the treatment the patient requested, and as a result avoided seriously harming the patient:

"This is something that a lot of osteopaths appreciate, because we see people who... come in with muscular-skeletal problems but in their general health they are fairly normal… generally quite well systemically. So when they have something which is a problem it tends to strike you… And it was just an intuitive thing that it would be completely inappropriate to manipulate this man. And I said to him… I didn't think that approach would be a good… I took the unusual step of ringing his GP and just explained what I thought. And his GP was very good, and they scanned him and he had got an aneurism. So, a nice twisting motion in manipulation could have been fatal." (4.29G1)

Like other osteopaths described above, the osteopath used this "near miss" as a learning opportunity:

"I thought afterwards, well you should have done an abdominal exam, and it would have come up straight away. So that was a kind of learning issue for me… It was something which was a near miss… It was a big reminder that… to get back into doing that regularly."

The incident also highlighted the importance for this osteopath of reflecting and learning with colleagues as a way of reducing the risks of damaging patients whose condition may be complex, uncertain and ambiguous, although they also noted that a lot of osteopaths did not have this opportunity:

"It is good to reflect with colleagues… most of us have close colleagues that we have either worked with or trained with, who you can offload and it is very important to exchange ideas and to hear how they would have done things differently… You still have got a lot of osteopaths who are working on their own… [and] haven't got that opportunity to share or learn from others about how they would do things or just basic bits of advice and experience that you can share." (4.29G1)

So here we see the importance of collegial support in helping osteopaths deal with and learn to address the uncertainty they faced in osteopathic practice and 'off-load' the emotional stresses associated with dealing with difficult patient problems.

We asked osteopaths what they thought were the most effective ways of ensuring safe and high quality osteopathic practice. Instead, three key related themes emerged from interviews: Reflective practice individually and with others; communications and conversation with colleagues (including osteopaths and other health professionals); and communication with patients. While these activities could have been included within CPD, only one osteopath explicitly mentioned CPD. One osteopath noted:

"Keep reflecting on your diagnosis. If you haven't got anywhere … discuss it with your colleagues… don't be alone with it; that is silly." (7.11G)

Another osteopath believed safe practice required:

"Knowing what your boundaries are… It is self-awareness really rather than anything that is written down in the Standards… [and using] the bigger support network… to have a chat and meet people… It is just important to stay in touch with people." (4.16Z2)

A third osteopath pointed to the importance of sharing experiences and learning from other professionals too:

"Sharing my experiences and learning from other people's experiences… other professionals and not just people from the osteopathic profession… surgeons, and consultants and professors of sports medicine… [who] can challenge some of the osteopathic principles" (4.15O)

Osteopaths, particularly those working in OEIs, also emphasised the importance of effective communication with patients:

"Communication is… always the area where it falls down… In my practice, the main thing I do focus on is making sure I have communicated what I am going to do, making sure that the patient is comfortable with me and that they have understood what we are going to do." (4.29G3)

"It was right the GOsC highlighted… communication. And that has always been almost the central plank in what we [OEI] do, and from day one with our students we say communication, communication, communication… We are talking about the totality of communication both verbal and non-verbal… From the moment you open the door, and you see that patient you are communicating with them and you are learning from them. The way they stand up… they move and the way their faces are structured… The way they talk to you – the way they look at you when they talk to you. All of these are telling you things. When a patient says 'yes' to you – they can say 'yes' to you in 101 ways" (5.14G)

In our survey, whist the majority disagreed (52%), 22% had 'worried that things I have done as an osteopath may not comply with the OPS'. The actions osteopaths were more likely to take when they worried about their practice were: 'I reflected on the issue by myself' (88%); 'I spoke with another osteopath or health care profession about the issue' (65%); 'I read up about the issue (56%); 'I read the OPS relevant to the issue' (49%). Few osteopaths said they contacted the Institute of

Osteopathy/British Osteopathy Association (14%) or GOsC (7%) for advice or did not take any action (18%).

We found a significant positive correlation (0.266) between longer qualified osteopaths being more likely to say they 'spoke to another osteopath or health care professional about the issue' they had worried about or 'read the OPS relevant to the issue' (0.169). Longer qualified osteopaths were significantly *less* likely to say they did not take action (0.272). Female osteopaths (mean 3.79 vs 3.34 for men) and those working with others (mean 3.69) rather than alone (3.27) were significantly *more* likely to speak to another osteopath if they had worried their practice may not comply with the OPS. In other words, more recently qualified, male osteopaths working alone appear least likely to speak to another osteopath or health professional if they are worried about practice not complying with the OPS.

In sum, many osteopath appear to experience problems and 'near-misses' in their practice, ranging from times they worried unnecessary to serious and potentially fatal incidents. Most of those osteopaths we spoke to had learned from and changed their practice as a result, often as a result of reflecting on the incident and discussing it with colleagues. Thus reflective practice and communication, learning and sharing with colleagues, rather than more formalised processes, appear to be important informal mechanisms for ensuring patient safety. However our survey data suggests an association between osteopaths being more recently qualified, male and working alone and being less likely to speak to another osteopath or health professional about worries practice not complying with the OPS. We return to this point in the following section.

Dealing with concerns about osteopathic colleagues practices

Next, we discuss osteopaths' experiences and views about reporting colleagues whose practices or behaviours concerned them. Our survey results suggest than a significant number of osteopaths have worried about their colleagues' competence.

28% of osteopath agreed: 'I have had concerns about another osteopath's ability to do their job' (56% disagreed), 41% of those within the last 12 months (52% disagreed). This finding is fairly consistent with the results of the 2012 GOsC Survey in which 31% agreed and 69% disagreed with the same statement (where there was no 'neither' option).

Osteopaths we interviewed talked about relatively benign cases relating to declining professional competence, without necessarily putting patients at risk, like the following account:

> *"One of our older members was clearly becoming less able… not quite on the ball… moving away from being entirely competent. But he has still got good stout hands and that bit hasn't gone. But you know he is kind of drifting away… And we did nothing as a community; apart from... talk behind his back about: "Let's hope he gets out of practice…" As far as I am aware he remained a safe and relatively competent practitioner, up to the point when he stopped treating." (4.16Z1)*

What is interesting here is that while osteopaths were aware of and talked about their colleague's declining competence, they did nothing to intervene. Some osteopaths interviewed had reported colleagues for behaving in ways that fell short of appropriate levels of professionalism:

> *"I did act …I raised it… They were promoting some kind of treatment which does not conform with the norms of osteopathy under normal muscular-skeletal medicine… It was more like in cuckoo land … there was no rationale behind it, no evidence whatsoever… I raised my concerns and something came out of it. And I felt angry, because it portrayed a different aspect of my profession. It is not the true aspect of the profession. (5.8O)*

Here the osteopath describes their motivation for reporting a colleague being their concern that their actions portrayed osteopathy in a negative light. Here it appears

that being part of a legitimate profession is important for this osteopath and their complaint appears to be a reaction to a colleague's action that undermined that legitimacy. So osteopaths maintaining legitimate professionalism may be an important element associated with complaints, with the osteopaths' own sense of collective professional identity, rather than standards per see, a key motivator.

However, other osteopaths described instances where osteopaths had not reported colleagues they were concerned about. For example, one osteopath described an osteopath who was "always known" to be "unprofessional" among osteopathic colleagues but was able to graduate from an OEI only to be later removed from the GOsC register:

> *"There was one particularly grim outcome of a Professional Conduct Committee… recently, that was a student… I unfortunately know, and we always knew… So it does make you slightly doubt… the integrity of the assessment processes, because in my head I think 'I always thought he was unprofessional'… Female members in the class, would say, "we don't like him working with us"… He just had a... nasty way of looking at women… He has got in trouble… now he has been removed from the register." (16.4G2)*

Another osteopath described a case of malpractice witnessed as a trainee:

> *"It still... bothers me. It was in the [OEI] clinic as a student… This girl came… to see me in the [OEI] clinic and spent half of the initial consolation telling me that she really didn't want to have any cervical manipulation. I went off and discussed this with my tutor… And he came into the room … and basically, he ordered me out of the way… and said, "Go … and get the cream, so that we can do some real deep tissue fibre work?" … When I got back … into the room this poor girl had a look of absolute horror on her face. And without her consent and with no warning he had basically gone and done a full rotation cervical manipulation … which is an assault! I had told him that she didn't want it. I heard her tell him… she didn't want it. But he had done it anyway.*

And when I brought that to the attention of the Head of Clinic at the time his response… was: "Because you weren't in the room and you didn't witness it, then unless she is willing to make a formal complaint there is nothing we can do." And she… didn't want any more trouble… It is shocking that someone could behave like that… terrifying that he was able to get away with it." (6.4O)

Accounts like this raise questions about the efficacy of local professional judgements and assessments and informal professional mechanisms for addressing professional malpractice. The account also highlights the importance of formal FtP hearings to address and prevent serious malpractice.

Osteopaths were often caught between knowing the importance of reporting serious concerns and having insufficient evidence to do so, as the osteopath below notes:

"If you have got any worries that a child or patient is being abused it is paramount that it is reported; their safety is paramount and you have to report it… [But] where do you draw the line? … If I have no evidence other than hearsay… I could not report it. If I did find the evidence I wouldn't have much problem reporting." (6.24G)

Another osteopath similarly noted that while they would 'flag' worrying things they heard about other practitioners, patients often misinterpreted what they said and did:

"[There are] varying degrees of seriousness… it depends ... I did have a patient once who said that her sister was seeing a practitioner, and it wasn't actually an osteopath, but he was doing some sort of strange massage technique on her where … he kind of straddled her body in some way and massaged the back of her neck, and she could feel his beard on the back of her neck… That isn't any technique that I am aware of … I would be very worried about it… If that had been an osteopath I would [have reported them to GOsC]… But

patients... sometimes they have selective memories … they say – 'oh so-and-so has told me that or told me that' – and you kind of think, I bet they didn't actually, I think they probably just misinterpreted that … Because even when they are coming ... they sometimes come and say – 'you told me last week that I wasn't to do this' – but no I didn't actually say that. So there is a degree of interpretation about these things." (4.23G)

Osteopaths were often reluctant to formally report colleagues because evidence relating to their concerns was ambiguous, commonly based on rumour and hearsay. Consequently they preferred more tentative, informal and exploratory ways of addressing concerns, as the following narrative described:

"Osteopathy mostly is not life or death. What we have to be incredibly careful of is basing an opinion of a practitioner on hearsay from patients… I have had patients tell me the most extraordinary stories, not necessarily of osteopaths, but of their GP or of their consultant or of their nurse or whoever. And my first impression now, as an experienced practitioner, is not to say: "Oh my God! That is dreadful how could that possibly happen?" But it is to say: "Oh, OK, that doesn't sound very good at all – have you managed to find a way to overcome this?" Patients can be dreadful witnesses. And if I start running around saying: "Oh my God! Have you heard such-and-such?" It is libel… or slander… I remember a patient being given some exercises to do. And the practitioner explained it all very carefully and very clearly… The patient then went out into the waiting room and told her husband what they had just been told to do and it was nothing like what they had just been told to do – nothing! So, of course, if you heard something that raised a concern you would log it. If you heard it again you would think 'mmm is this a pattern?' And you might possibly ring a colleague who knows this person or just say: "Have you heard anything? … Got any concerns?" I suppose your next port of call would be to contact the practitioner but I really don't know how that conversation would go, when we haven't all yet developed the capacity for

these conversations. It would have to be pretty serious and confirmed by more than one source to involve the regulator." (05.06G1)

We asked the osteopath what they meant by 'serious', to which they replied: "anything of a sexual nature" reported by a "reliable witness" (05.06G1). Other osteopaths similarly defined 'serious' as involving sexual boundary violation or dangerous practice likely to injure patients:

"A serious risk, for example, if I thought they were abusing children, well then I wouldn't even be calling the GOsC I would be calling the police." (4.14O)

"Serious complaints… inappropriate potentially sexual conduct… [or] cases where people do injure people" (4.17 M)

"Serious, like sexual boundary violations or complete incompetence or doing dangerous things". (4.16G3)

"Serious allegations … sexual misconduct is an important one." (4.25G)

"Touching patients' breasts or [genitals] or the osteopath hurts the patient" (5.21O)

Others defined serious as "criminal" "really offensive" or "horrific" behaviour:

"Serious… something that was criminal or really offensive, something that was a criminal offence then I certainly would report it to GOsC and then further if it was horrific." 4.15O

"There is obviously criminal extremely serious practice and there is a spectrum… I had an associate physiotherapist, twenty-five years ago… who I thought was over-undressing patients – the female patients - It is not necessary to make everybody take their bra off. And he was eventually

summoned to the Professional Conduct Committee for inducing the patient to have a perineal massage which I think is an unusual osteopathic approach. I think he was abusive." (6.6G1)

So due to the ambiguity over evidence of malpractice among their peers, often from hearsay, and the different ways in which comments and behaviours could be interpreted, osteopaths were reluctant to formally report all but their most serious concerns (involving sexual abuse, serious criminality or actual harm to patient).

Dealing with concerns informally

Osteopaths appeared to believe it was more appropriate to address concerns about colleagues not meeting standards informally within the profession:

"If I saw something that I wasn't happy with, perhaps a breach of Standards, I would immediately discuss that with the practitioner… I wouldn't necessarily run off to the GOsC … because it would have to be a repetitive thing and the clinician would have to not accept it… then potentially I could ... report it. But in the first instance I would probably discuss it with my peers and see what they thought about it to be honest." (05.01 Z2)

Osteopaths appeared more likely to speak to osteopaths they knew , if they were worried about them, or encourage patients involved to make a complaint if the allegation was serious and the osteopath did not know their colleague:

"Say a patient came to me and said 'I went to see this other osteopath and he was really inappropriate in the way he touched me.' … I would discuss it with that person [patient]… Would I get in touch with that osteopath? …If I knew them better I would… somebody you didn't even know why would you; you wouldn't would you. You would just say to the patient – 'are you going to complain?'... because if you don't then I will." (4.16G2)

Importantly, osteopaths appeared to consider reporting osteopathic colleagues to the GOsC as causing them harm or trouble and there appeared to be an absence of mechanisms for supporting osteopaths who were in difficulty, as the following example illustrates:

> *"A graduate rang me while I was a clinic tutor, in the evening… He wasn't a student... I didn't know him that well. I did think it was very inappropriate… He wanted to talk to me about a patient that kept coming to see him wearing revealing underwear. At the time I thought, you just want to talk, I just thought his motives were not about wanting professional advice and he also sounded drunk… Would you report him or not? I didn't do anything. There was a really sad outcome to that particular guy, who was having all sorts of problems… He had been going through a divorce, he had alcohol problems and an ex-partner had reported him to GOsC and so he was investigated by GOsC, and he ultimately drank himself to death… I didn't do anything, because he was having a hard enough time. But there was something ... not right." (4.16G2)*

The consequence of osteopaths being subjected to difficult FtP hearings, and lack of support mechanisms to osteopaths in trouble, seemed to deter osteopaths from reporting their concerns, meaning that concerns may not be picked up and potentially remedied. One osteopath noted:

> *"I would be concerned if I thought somebody perhaps... was ... addicted to something, perhaps alcohol. I don't think we have got much of a mechanism for intra-professional support… it is an unspoken anxiety… What do you do if somebody is not well? … the practitioner's... standards slip a bit, because of the stresses? …. Over the years that has been my worry. I have been through times of extreme stress and thinking, I am just about hanging on in here, if I made a mistake how would that go?' (6.6G1)*

This raises questions about whether a more supportive, developmental and professionally-owned approach to Assuring Continuing Fitness may be more effective in dealing with poor osteopathic professionalism and practice?

Other osteopaths, like the one who described poor practice they had witnessed as a trainee which had gone unreported within the profession, commented:

> *"I don't see how any form of regulation could account for that, because unless the patient is willing to make a complaint there is no basis on which that kind of behaviour can be rooted out. And this is why I say again – it is all about the culture in the environment in which people train." (06.04O)*

The osteopath giving this account concludes that the solution to raising concerns about other osteopaths' practice or professionalism is cultural rather than to do with regulation, involving changing cultural norms, reflecting previous research (Waring, 2005) on cultural barriers to the reporting of adverse clinical incidents. Addressing and picking up poor quality osteopathic professionalism and practice may involve a twin approach of introducing processes to support osteopaths in reporting concerns and cultural change. An interviewee who sat on a GOsC committee dealing with concerns about osteopath's practices suggested that while osteopaths were likely to hear about poor practice there was an absence of mechanism to deal with them before they became a formal complaint:

> *"In a small disparate profession like osteopathy, where people practice very much on their own... they may hear about... but they don't see what is going on in terms of poor conduct by other osteopaths… If there are two or three patients who have said something about someone, there doesn't seem to be a space in the system for anyone to do anything, until it is passed the holy grail of being called 'a complaint' or 'an allegation' or something with a sort of formal status." (22.4G GOsC Committee Member)*

An osteopath made a similar point; contrasting the way mistakes were dealt with in a 'no blame culture' within the aviation industry with osteopathy, where there was seen to be 'no support mechanism' to help osteopaths deal with mistakes:

> *"My [relative] is an air-traffic controller… governed by the Civil Aviation Authority… subject to re-regulation on an annual basis … in a very regulated environment but … more of an open … no blame culture. And that means that if they make a mistake and there is an investigation, and they are deemed to have made a mistake, rather than there being a massive prodding finger saying, "You were very bad and we are going to dish out this punishment to you", usually their first line is… what lessons can be learnt from this to make sure this never happens again to another individual… often it is dealt with at a local level… There is absolutely nothing like that for us [osteopaths]. If we make a mistake there is no support mechanism for an osteopath, unless you physically go out and seek it yourself." (5.15O)*

Training and support for osteopaths to be more able to have 'difficult conversations' about problems appears to be needed. One osteopath we interviewed referred to the way the aviation industry dealt with potential problems and an airline pilot they treated as a patient, who was involved in developing protocols and training people in how to have difficult conversations in the aviation industry. The osteopath noted:

> *"I treat an airline pilot who does a lot of development work … education and training… [about] … having these conversations… There have been examples of planes actually crashing because something wasn't right and nobody dared to tell the pilot, even though they saw that something was not right… So they have … a code. If you see something that you think is wrong your first decision … is, "what time frame do I have for something to be righted?" If it is 20 minutes I can sit back for 5 and then maybe I can gently raise a concern with someone else who can then pass it put the chain. If it is instant, we are about to die, you have the responsibility to immediately convey that information." (5.6G1)*

Developing protocols and providing training in how to have difficult conversations may be important in helping osteopaths to challenge colleagues they have concerns about. Indeed interviewees from OEIs noted that, following the introduction of the 'duty of candour' they had already been encouraging students to raise concerns and training them in how to have "that conversation":

> *"The duty of candour… we have tried to introduce it into our clinic protocol, to talk about what it means as a student and as a practitioner. And we did actually have a junior student saying: "It is not my place to raise the issue; what do I know?" And we said: "No, no, no, this is exactly ... you must!" But you need to have a way of having that conversation." (05.06G1)*

We suggest that creating spaces in which osteopaths can have 'that conversation' about potentially problematic osteopathic practice or professionalism is important, as we will discuss in the following section.

Previous research has suggested that osteopaths and patients are often unclear about the distinction between less serious 'run of the mill' issues that are better addressed between osteopaths and patients those that need to be reported to the GOsC (Leach et al., 2011). Another osteopath suggested GOsC might take a less rigid approach to complaints, formally investigating osteopaths for serious matters but only warning them for less serious matters:

> *"Osteopath is convicted of drunk driving… bad advertising practices… Pictures of you at a party… all over Facebook and you are looking absolutely [drunk]… Here is a warning… we are not going to investigate you, you are not going to have to get a lawyer, you don't have to turn up for a hearing, you don't have to write a report." (5.21O)*

How common are the experiences interviewees described? Most osteopaths seem to agree with the importance of reporting colleagues for 'serious malpractice' in

principle, although the definition of 'serious' was ambiguous (osteopaths mentioned sexual boundary violation or where patients were at risk of physical harm as serious). So it may be important to define serious malpractice more clearly. 82% of osteopaths in our survey said they 'would always report another osteopath to the GOsC for serious malpractice' (only 2% disagreed). Most osteopaths (61%) say they are 'clear about when to report another osteopath to the GOsC (21% disagreed) and about half (48%) agreed 'I am clear about how to report another osteopath to the GOsC (26% disagreed). However, almost two thirds (63%) of the osteopaths responding to our survey agreed that 'Unless it is serious, it is better to deal with concerns about another osteopath informally, rather than go through a formal regulatory process', and few (8%) disagreed.

Our exploratory factor analysis indicated an aggregate factor (9) relating to 'Clarity about reporting colleagues' poor practice' (mean response 3.60, where 5 indicates strongly agree and 1 strongly disagree) comprised of three factors (i) I am clear about when to report another osteopath to the GOsC; (ii) I am clear about how to report another osteopath to the GOsC; (iii) I would always report another osteopath to the GOsC for serious malpractice (e.g. where patients are at serious risk). Clarity about reporting colleagues' poor practice (Factor 9) was not significantly associated with any demographic variables.

While 59% of osteopaths who had had concerns about another osteopath's ability to do their job had considered reporting another osteopath for actions they thought were wrong or unethical (41% disagreed), few (20%) reported actually making a formal complaint (10% to the GOsC; 5% to the British Osteopathy Association and 5% to the osteopath's employer). Osteopaths appeared more likely to address concerns about their colleagues informally. 11% said they spoke to the osteopath in question; 23% gave advice to a patient affected by the osteopath; 26% discussed the osteopath with other osteopaths or health professionals. 9% decided the concern was not serious or credible enough for further action and 10% said they did not take any action. These results appear to triangulate data from interviews suggesting that

osteopaths tend to take an informal approach to addressing concerns about their colleagues.

In our survey, we asked osteopaths why they did not report concerns about colleagues, drawing upon questions used in previous research (Firth-Cozens et al., 2003) on doctors' and nurses' attitudes and experience of reporting poor care. Reflecting data from interviews about the ambiguity of evidence, the majority (53%) of osteopaths reported 'my concern would have been impossible to prove'. 37% said 'the issue was resolved', 36% said 'I did not want to cause trouble'; 30% said they 'feared retribution' ; 23% felt they 'would be hurting colleagues' and 23% 'could not tell tales'. These survey results again reflect interview accounts about interviewees believing FtP hearings were punishing experiences and not wanting to add to the difficulties of their colleagues in trouble. 19% said they 'were isolated in their suspicions'. Few osteopaths (18%) said they did not report poor concerns because 'no one would support me', because they were 'advised against it' (14%), 'had no one to talk to about it' (13%) or would 'not have been listened to' (12%).

We analysed responses to our survey questions about concerns about colleagues' practices by demographic criteria. The longer osteopaths had been qualified, the more likely they were to report 'I have had concerns about another osteopath's ability to do their job' (48a; correlation 0.131) and those working with other osteopaths (2.71 mean vs 2.47) and osteopaths who had had a complaint made against them that did not go to the GOsC, were also significantly more likely to have had concerns about colleagues' abilities to do their jobs. These responses are perhaps unsurprising as these osteopaths are more likely to have been exposed to or reflect on other osteopaths practices.

Significantly more women than men who did not report concerns said they did not do so because 'no one would support me' (mean 2.79 vs. 2.41) or because they were 'advised against reporting the osteopath by colleagues' (2.92 vs 2.00). This is an interesting finding, the reasons for which are unclear.

We found a significant *inverse* correlations between time qualified as an osteopath and survey respondents not reporting colleagues for the following reasons: 'My concern would have been impossible to prove' (-0.184); 'I feared retribution' (-0.31); 'I did not want to cause trouble' (-0.221); 'I would not have been listened to' (-0.23); 'No one would support me' (-0.201); 'I could not "tell tales"' (-0.246); 'Reporting the osteopath might have had financial costs for me' (-0.251). These findings are perhaps because more recently qualified osteopaths may be less sure of their practice and position as an osteopath within their profession and reflect the findings of interviews, particularly the quote relating to 'duty of candour' and trainees unwillingness to report poor practice or professionalism. These findings suggest the work some OEIs are doing to encourage trainee osteopaths to report their concerns is important.

Those osteopaths who had a complaint made against them to the GOsC were significantly *more* likely to say they did not report concerns because 'the issue was resolved' (mean 3.64 vs 2.85) and *less* likely to not report a concern because they 'feared retribution' (mean 2.0 vs 2.78), 'would not have been listened to' (mean 1.68 2.68) or believed 'no one would support me' (mean 1.64 vs 2.64). This suggests that, having had a complaint reported against them, these osteopaths believed, first, that problems were more likely to be resolved informally and, second, that complaints are taken seriously by the GOsC (listened to, supported and not subject to retribution).

Those who had had a complaint made against them that did *not* go to the GOsC were significantly *more* likely to say that they did not report a concern about a colleague because the issue was resolved (mean 3.54 vs 2.78) and *less* likely to say they did not report a concern for other reasons ('My concern would have been impossible to prove' (2.73 vs 3.32), 'I feared retribution'(2.09 vs 2.81), 'I did not want to cause trouble' (2.14 vs 2.97), 'I would not have been listened to' (1.82 vs 2.73); 'No one would support me' (1.86 vs 2.68); 'I felt I would be hurting a colleague' (1.95 vs 2.79); 'I could not "tell tales" (2.05 vs 2.64); 'I was not sure if my concern was right' (2.09 vs 2.67); 'I had no one to talk to about it' (1.91 vs 2.38); 'I was advised against

reporting the osteopath by peers' (1.86 vs 2.46); 'Reporting the osteopath might have had financial costs for me'(1.77 vs 2.38)). Again, this may have been because, having had a complaint made against them personally, these osteopaths believed complaints and concerns were best resolved informally but that formal complaints were taken seriously and supported by the GOsC.

Summary

In sum, we examined how osteopaths reacted, or said they would react, to concerns about colleagues' practice or professionalism. Most osteopaths in our survey agreed the importance of reporting serious malpractice (82% of survey respondents said they would always report serious malpractice). A significant number of osteopaths (28%) said they had been concerned about a colleague's ability to do their job (particularly longer serving osteopaths, osteopaths working with others or osteopaths who had had a complaint about their practice that did not go to the GOsC). However osteopaths appear reluctant to report suspected breaches of standards, which we have illustrated with interview narratives.

Some osteopaths said that they would act to report a colleague where there was clear evidence of poor practice, or where, for example, they had clear responsibility to protect a child at risk, which would override other concerns. However, an important theme in interviews was about differentiating hearsay and rumour from actual, first hand evidence. Previous research (Leach et al., 2011) has also highlighted a lack of clarity between 'run of the mill' issues that are best addressed informally and more serious concerns needing to be reported to the GOsC. One reason for not reporting concerns about colleagues' poor practice was the ambiguous nature of evidence of malpractice, often based upon hearsay, meaning that osteopaths concerns would have been impossible to prove and allegations might be slanderous. Indeed in our survey, 53% of osteopaths who had been concerned about a colleague but did not report their concern said this was because their concern would have been impossible to prove.

Several osteopaths described examples of colleagues who were undergoing stressful life experiences and seen to already be experiencing significant problems, and the osteopaths we spoke to did not wish to make their colleagues' circumstances even more challenging by reporting them to the GOsC. Indeed many of the respondents to our survey did not report concerns because they did not want to cause trouble or hurt colleagues or because 'the issue was resolved' (informally).

Instead, therefore, from both interview and survey data, it seems that osteopaths tend to deal with concerns informally; speaking with colleagues they are concerned about if they knew well enough to do so, or encouraging patients to make complaints or discussing concerns with colleagues if not.

Significantly more female osteopaths said they had not reported concerns about colleagues because they did not feel they would be supported or were advised against doing so by colleagues. More recently qualified osteopaths appeared less likely to report colleagues for reasons that appeared related to their insecurity as an osteopath. Osteopaths who had been subject to complaints (both to their practice and to the GOsC) were significantly more likely to say they did not report concerns because 'the issue was resolved' and significantly less likely for most other reasons, perhaps because they believed informally addressing concerns was most appropriate, although the exact reasons for this are unclear.

Osteopaths expressed a wish for greater sharing of practice, learning from peers, and of gaining feedback about their own practice. We heard of efforts to introduce a duty of candour, which as one senior osteopath told us "needs to be learned", as ways to surface concerns or questions about practice. Encouraging candour among students in OEIs appears particularly important, as more recently qualified osteopaths were significantly less likely in our survey to say they would report concerns compared with longer qualified colleagues. This was seen less as reporting or raising complaints than of bringing to the surface questions, concerns, challenges in ways that could be openly discussed with the aim of changing practice. However,

facilitating ‘that conversation’ requires not just the introduction of new regulatory processes and standards but changing the culture of osteopathic practice, setting norms and expectations through peer and leadership arrangements, sometimes in combination with learning and development interventions. We will discuss this theme further in the following section.

8. Strengthening professionalism by creating 'formative spaces' in 'peer discussion review'

The previous section shows how it is important for osteopaths to have regular and routine opportunities for reflection and communication with colleagues through which they can maintain safe and high quality practice. In this section we discuss the potential for 'peer discussion review' within the GOsC's continuing fitness to practise process to address risks associated with the isolated nature of osteopathic practice. This represents a major recommendation from our work based upon comprehensive empirical findings and the available literature on regulatory practices.

Drawing together the above findings, we begin by discussing the isolated nature of osteopathic practice, the responses to the GOsC's revalidation pilot and the consequent development of a more formative and developmental approach to assuring continuing FtP, involving what the GOsC term 'peer discussion review', reflecting regulators' and osteopaths' views about the importance of having the opportunity to talk to colleagues in a safe environment. We conclude that *informal* peer discussion (review) within the continuing FtP process would be useful but also raise potential problems that would need to be addressed. We also suggest a 'risk based' or 'right touch' approach to assuring continuing FtP. Less serious concerns about osteopaths' practices may be best handled informally and developmentally by osteopaths within the peer discussion review process and only 'red flags' involving *serious* concerns need to be referred to FtP investigatory committees and hearings.

Isolation in osteopathy

Osteopaths often work independently from other osteopaths or health professionals, sometimes in their own homes or rented practice rooms. Other osteopaths work in larger practices, co-located with other osteopaths or independent health professionals (KPMG, 2012b). 45% of osteopaths who responded to our survey said that they worked alone. However even osteopaths working in practices with others may have little day-to-day contact or discussion of

their practice with clinical colleagues. Indeed osteopaths we interviewed described their profession as "lonely" (5.14g) and often working in "isolation" (5.15O), with little regular contact with other health professionals, and many commented that they would like more opportunities to reflect on and talk about their practice with other osteopaths. One osteopath, for example, noted a lack of mentoring early in their career:

Having other osteopaths to talk with was seen to be important for osteopaths. An osteopath commented:

> *"I would have really liked a mentor in… the first year [as an osteopath, which] was very lonely." (5.30Z)*

Another noted:

> *"I don't … get the opportunity to discuss difficult cases with sort of well-experienced osteopaths… I have probably got some valuable insight to offer and I know that I could learn a heap from other people… I just would love to be able to have that sort of thing available."* (15.5O)

There is evidence that professionals working in isolation are at greater risk of disengagement and clinical malpractice (Cox and Holden, 2009, Holden et al., 2012, Picker, Forthcoming)[13] and this was an issue that troubled many people we interviewed from health professional regulators, including the GOsC. As an interviewee from another regulator put it:

> *"People getting isolated and not keeping up to speed in their practice, and not submitting themselves to anyone scrutinising or auditing what they are up to… research… [has found] working in an isolated practice … you are much more likely to... move towards underperformance" (6.2G)*

[13] http://www.hpc-uk.org/assets/documents/10004605EducationUpdate-Issue16-May2014-e.pdf (see p6).

An interviewee from the GOsC noted:

> *"The problem is… professional isolation… [Osteopaths] don't necessarily have contact with other osteopaths, … other healthcare professionals, or NHS standards, or systems of appraisal and… structure which can help you raise your game… to compare and see levels of professionalism." (3.31G)*

Thus lone practice was seen to reduce osteopaths' exposure to others' practice and opportunities for multi-disciplinary working, perhaps limit scope for innovation and learning, and also reduce the scope for variations in practice to be detected before escalating to become more significant problems. Finally, lone practice may also place emphasis on the professional being a self-directed learner, unlike professionals working in the NHS organisations as parts of teams. As one sole practitioner noted:

> *"I am a sole practitioner… the pressures of your day-to-day work [means]… if you … wanted to discuss a case it is always a very 'snap' discussion … There isn't any opportunity to sit down … and say… 'I don't think I dealt with that case very well at all… I am concerned that I chose the wrong treatment for that patient' … I don't think there are any support mechanisms. Even sort of ten years or eleven years down the line of working – I still would welcome an opportunity for that." (5.15O)*

So for osteopaths not working with osteopathic peers, the regulator and their client may be their primary external reference point.

Our analysis of survey data found no significant variation between factors for 'favouring formal peer review' (Factor 1; with a mean response 2.57, where 5 indicates strongly agree and 1 strongly disagree) and 'favouring informal peer review' (Factor 2; mean response 3.26) and time qualified as an osteopath. This suggests that osteopaths who work alone are significantly *less* likely to favour formal peer review (Factor 1; mean 2.48 vs 2.64), informal peer review (Factor 2; mean 3.16

vs 3.34), be 'Pro-GOsC' (Factor 5; mean 2.89 vs 3.01) or believe osteopaths should be regulated by law (3.98 vs 4.2). They are also significantly less likely to have 'had concerns about another osteopaths' ability to do their job' (2.47 vs 2.71) or to have spoken to another osteopath or health care professional if they had worried their practice might not meet the OPS (3.27 vs 3.69).

From Osteopathic Revalidation and Peer Review to Assuring Continuing Fitness to Practise and Peer Discussion Review

The GOsC had consequently been trying to address the potential problems associated with professional isolation by developing peer review processes to provide assurance that osteopaths would practice in line with the OPS. The GOsC initially piloted a revalidation scheme in 2011-2, involving peer review, which was evaluated by KPMG (2012a).

Our research reflected the findings of the KPMG report (KPMG, 2012a) on the GOsC's 'Revalidation Pilot'. Osteopaths we interviewed who had participated in the revalidation pilot commented that it was: *"incredibly burdensome... difficult to tune in to the language of it"* (16.4Z2), which was: *"dry legal language, which will send most people fast asleep. By the time you got halfway down the page you have given up the will to live. It did take me 7 or 8 times reading it, to actually get the gist."* (6.24G). Other interviewees similarly noted: *"The documents were written in such a laboured educational-speak way, so probably just disengaged an awful lot of people"* (29.4G2) and that it was *"difficult to think how that applies to you, or how you can use [it]… the pilot process… wasn't very helpful" (4.23Z1).*

Instead the osteopaths we interviewed wanted a process that was: *"more reflective and that people can engage in at a personal level… as a way of helping themselves rather than just this big onerous task that they have to do once a year… like a tax return!" (4.17M)*

While the revalidation scheme that GOsC piloted was seen to be "unworkable", the GOsC won praise from several osteopaths we interviewed for the way it had modified plans for revalidation after listening to osteopaths' feedback:

> *"Like most of my colleagues, I didn't like the idea of [Revalidation]… There was a trial run, which was unworkable and they [GOsC] had the good sense to say so and modify it. And that is something I would really congratulate GOsC on; they really listened… It showed... a change of attitude… a really positive step to listen and to take notice." (9.4G)*

Following feedback from the Revalidation Pilot, the GOsC redesigned and renamed its proposed revalidation scheme, which focused on *formative* 'CPD providing assurance of continuing FtP' by preventing poor practice and professionalism rather than the previous more *summative* assessment osteopaths' FtP. A GOsC interviewee noted that the new continuing FtP scheme involved:

> *"More of the development side of stuff; that way you are preventing things from happening, rather than what we do at the moment… even learning that you are struggling with the same issue, gives you some reassurance… to learn that you are not alone." (3.31G)*

A member of a GOsC committee commented:

> *"Peer review would be hugely helpful… [because a] person who is supremely confident… are probably not recognising what they need to improve on and there are probably nine out of ten people who are recognising that they are a bit below par in some area but who do they talk to about it? …. So having some structures around that and it has got to be a good idea… in a sort of non-threatening way." (4.22G)*

One key change in the new GOsC scheme proposed to assure Continuing FtP, is the introduction of 'peer discussion review', in which osteopaths would discuss their

practice with another osteopath, or other health professional, on a three yearly basis (see 'Item 10' of a Report to the GOsC Council on 17th October 2013 and *The Osteopath*, Dec 2013/Jan 2014, p.6-7. Also see Appendix 1 for a discussion).

Many osteopaths we interviewed appear to welcome the opportunity to discuss their practice with a colleague and suggested that it would be a useful way to address potential problems osteopaths face in practice. An osteopath who worked part-time in the NHS commented:

> *"There is no mentorship [in private osteopathic practice]… Whereas in the NHS… I still have a clinical supervisor… somebody to discuss and to reflect with… We all have near misses at some point… We discuss it… You can't hide and that is the whole point… if you are not coming forward with problem patients to your clinic supervisor… it means you are hiding, because even the most experienced clinician would have difficult patients or issues you need to discuss." (5.8O)*

One osteopath we interviewed had supervision with a psychotherapist and participated in an osteopathic study group. They noted:

> *"I have supervision with a psychotherapist, because I think it is really important that you have somewhere to go to talk about what happens… I recognised fairly early on that I needed somewhere where I could go and talk about the patient-practitioner relationship… I could talk to colleagues about patient management, technique or approach… but I couldn't talk about the patient-practitioner relationship in the same kind of way… Most of us work in isolated private practice and it is good to… talk about how we feel… Mentoring, small groups and stuff like that are really, really good, we set up a study group, which was great… it meets that need of emotional support and critical analysis" (4.16Z1)*

Another osteopath discussed the importance of talking about problems arising in osteopathic practice in order to address them more proactively:

> *"An off-loading process … is very healthy, so that you don't worry about things and let them fester. You talk to someone about them and you do something that is proactive, either in terms of managing a situation… or reflecting on how you might deal with a situation in theory." (4.29G1)*

Other osteopaths noted the importance of discussions with 'critical friends' in a 'safe environment' to avoid becoming isolated in their thinking:

> *"A safe environment where they can be [with] a critical friend… is very important… as autonomous practitioners, [because] it is very easy to get isolated in your thinking, if you are not in group practice, where you discuss the pros and cons and are not looking at the bigger picture and not maybe understanding how we have to fulfil certain criteria to be able to move forward." (4.23Z1)*

Peer review was also seen to be important for more experienced osteopaths too. Evidence from other clinical professional groups[14] [15] suggests that professionals are at greater risk of clinical disengagement and consequent poor practice or professionalism when they have been in practice for more than 25 years. One self-declared 'older' osteopath noted:

> *"[As] an older practitioner... done all your studying such a long time ago, it is quite nice to have somewhere where you could safely share your concerns and areas that you want to develop and not feel like under threat… CPD is very critical."* (4.23Z2)

14 http://www.gmc-uk.org%2F4d Developing Risk based Regulation Progress Report annex A .pdf 25398949.pdf

15 http://www.hpc-uk.org/assets/documents/10004605EducationUpdate-Issue16-May2014-e.pdf (see p6)

We asked interviewees about their views of 'peer review discussion' as part of the processes to assure continuing FtP. Most agreed that more sharing among osteopaths would be useful:

> *"We probably don't make as much use of sharing with colleagues as we might… Peer review… is a bit scary and it's slightly out of your comfort zone, if it is something that you have never done. But if you go about it the right way and if you learn from professional groups that have done it, and seen the pitfalls and the things to avoid, then I think it has merit. I have to admit when I first heard of it I thought, grimace, argh… But once I had heard more about it, and the thinking behind it, then it did start to make more sense." (4.29G)*

Thus clear communication and early education and training relating to peer review may be important for many osteopaths. Another osteopath commented that talking with another osteopath, as part of the peer review, would help osteopaths understand how to improve their practice:

> *"[To] have an experienced osteopath… and maybe talk to them about what you have done, and where you want to develop your practice… would be really useful… probably more useful than a revalidation. I did find [in the revalidation pilot]… you could tick all the boxes and fill all the forms… without actually transferring that into practice… Peer mentoring… would mean that you would have to translate things into practice more." (6.6Z1)*

An osteopath suggested that peer review might be a way to get through to "non-reflective" osteopaths, at risk of engaging in dangerous practices:

> *"Non-reflective people… are the most dangerous… Unfortunately the group that are worried about being struck off, they are the very ones that probably would be too paranoid to do that [reflective practice]… probably something like mentoring is the only thing where there would be a real check." 11.7G*

Our analysis of survey data found no significant variation between factors for 'favouring formal peer review' (Factor 1) and 'favouring informal peer review' (Factor 2) and time qualified as an osteopath. However we did find a significant *inverse* correlation (-0.88) between agreement with the statement 'Peer review, involving informal discussion of my practice with another osteopath, would have a positive impact on how I practise as an osteopath' and time qualified as osteopath. So longer serving osteopaths appear less in favour of informal peer review based upon responses to this question.

Female osteopaths were significantly more likely to agree that they would be able to 'bring up tough issues and problems' during a peer review as part of the GOsC assuring continuing FtP process' (mean 2.91 vs 2.70). Female osteopaths were also significantly more likely to agree that 'maintaining my GOsC registration helps me to reflect on my practice' (mean 3.05 vs 2.85).

In sum, most osteopaths appeared to welcome the opportunity for greater discussion of their practice with other osteopaths, as a means for learning how to address, share and off-load worries about problems they were facing. Peer discussion appeared to be useful for new osteopaths as well as older ones, who are potentially at risk of professional disengagement. We found no variation between favouring formal peer review (Factor 1) and favouring informal peer review (Factor 2) by time qualified as an osteopath, although those more recently qualified agreed that informal peer review would have a positive effect on their osteopathic practice. From analysis of survey data, female osteopaths appeared more likely to reflect on their practice while maintaining their GOsC registration and so say that they would be able to bring up problems and tough issues during a formal peer review. While osteopaths may require some education and training about the peer discussion review process, it seems that discussion within this process is an important element in translating learning from peer review into practice, which would be generally welcome among osteopaths.

Potential problems in peer discussion review

However osteopaths did raise some potential problems with peer discussion review. The first problem with introducing peer discussion review may be that, regardless of the intent with which the process is introduced, many osteopaths are likely to be wary of the process. As one osteopath noted:

> *"Peer evaluation… lots of sole practitioners might feel quite threatened … especially people who have been around for a long time, and were around when the original Statutory Regulation process went ahead." (4.16G2)*

Another osteopath noted that many of their colleagues were:

> *"Frightened about being too honest with their CPD… reflective and looking at their needs, because they are worried about what it means for them."*
> (23.4Z2)

The result of our survey raise questions about how enthusiastic osteopaths are about peer review. Only 34% of osteopaths agreed that 'peer review would have a positive effect on how I practise as an osteopath, as part of the GOsC process to provide assurance of continuing FtP', with a higher number (37%) disagreeing, with 29% unsure. Only 30% of survey respondents agreed (40% disagreed) that they 'would be able to bring up problems and tough issues during a peer review, as part of the GOsC process to provide assurance of continuing FtP'. So osteopaths appear wary of formal peer review as part of the GOsC FtP processes.

However, the majority of osteopaths (52%), agreed that 'peer review, involving *informal discussion of my practice* with another osteopath, would have a positive effect on how I practise as an osteopath' (24% disagree) and 69% agreed they 'would be able to bring up problems and tough issues during a peer review *involving informal discussion* of my practise with another osteopath' (12% disagreed). Thus,

the majority of osteopaths believe *informal* peer review would improve their practice and most osteopaths said that they would be able to discuss problems during an informal peer review process. Therefore it appears important that the peer discussion review process is informal if osteopaths are to engage with the process.

Osteopaths voiced concerns about having a peer reviewer 'imposed upon them' and spoke of the need to choose their peer reviewer:

> *"Having someone imposed upon you… from a very different philosophical place… they may say that what you are saying is nonsense and get hot under the collar… So you would need to choose or want the person who is going to be assessing you in order to be able to openly talk about things… If you had a pool of people that you could select from, or you would have to give a good rationale for why you selected that person… that would be quite helpful. I think that is useful" (29.4G1)*

The findings of our survey reflect the importance of osteopaths being able to select their own peer reviewer. 43% of survey respondents said that peer review would have a positive impact on their practice if they chose their peer reviewer but few, only 18%, agreed if the peer reviewer was appointed by the GOsC. 50% said they would be able to bring up problems and tough issues during a peer review discussion if the peer reviewer was chosen by them but few, again only 18%, said they would be able to do so if the peer reviewer was appointed by the GOsC. Thus while peer discussion review may be a good idea in principle the way GOsC communicates and educates osteopaths about the process and implements it are likely to significantly affect its impact in practice. It appears important that osteopaths are able to choose their peer reviewer if they are openly discuss difficult issues and problems they may be facing in practice.

There are risks associated with allowing osteopaths to choose their peer reviewer. Some worried that peer discussion reviews might not be objective, could be open to "buddy abuse" and would be difficult to "quality assure":

"If it is left to having someone signing off your form, it will be open to buddy abuse… I will sign your form and you sign mine, which we already know goes on with the CPD things… [So we need] trained mentors [with]… responsibility for signing off." (5.6G1)

"Could you quality assure it? … As with any population I think you would probably get 80% of the population would do it, and you would still have your other ones who will sit there until the last moment… It can just turn into a let's have a glass of wine and chat about a few patients." (6.6G2)

The results of our survey suggest that few osteopaths are confident that 'Peer review would produce fair outcomes, as part of the GOsC process to provide assurance of continuing FtP (19% agreed; 41% disagree), reflecting a fear of regulation among osteopaths, which we have discussed elsewhere in this report. However, again, osteopaths are appear positive about the fairness of informal peer review; 42% agree 'peer review, involving *informal* discussion with another osteopath, would produce fair outcomes' (18% disagree); 15% agree if the peer reviewer is appointed by the GOsC; 34% agree if chosen by the osteopath.

Our exploratory factor analysis indicated a number of factors linked to an aggregate factor which we refer to as 'Favouring formal peer review' (Factor 1) and 'Favouring informal peer review' (Factor 2). We found that osteopaths working with others (mean 2.64 rather than 2.47 for those working alone) and those who had reviewed a complaint that did not go to the GOsC were significantly more likely to favour formal (mean 2.74, vs. 2.53) and informal peer review (mean 3.47 vs 3.23). Those who had received a complaint that went to the GOsC (mean 3.50 vs 3.25) were significantly more likely to favour informal peer review (Factor 2).

Osteopaths working with others (rather than alone) were significantly more likely to agree that 'peer review would have a positive effect on how I practise as an osteopath, as part of a GOsC process to provide assurance of continuing FtP'; 'peer

review, involving informal discussion of my practice with another osteopath, would have a positive effect on how I practise as an osteopath'; 'I would be able to bring up problems and tough issues during a peer review, as part of a GOsC process to provide assurance of continuing FtP'; 'peer review would produce fair outcomes, as part of a GOsC process to provide assurance of continuing fitness to practice'; 'peer review, involving informal discussion with another osteopath, would produce fair outcomes'.

Those who had been subject to a complaint that did not go to the GOsC were significantly more likely to agree that both 'peer review would have a positive effect on how I practise as an osteopath, as part of a GOsC process to provide assurance of continuing FtP' and 'peer review, involving informal discussion of my practice with another osteopath, would have a positive effect on how I practise as an osteopath'.

One interviewee, from an OEI, suggested that having a peer reviewer from an OEI might demonstrate that peer reviews were more effective.

> *"Having a kind of a mentor who works at an OEI might be a way of demonstrating that you haven't just gone down for coffee with your mate and signed the box but that you have actually got somebody objective." (23.4G)*

However, the results of our survey suggest that few osteopaths are positive about peer reviewer being accredited by OEIs or other osteopathic bodies. 25% said peer review would have a positive effect on their osteopathic practice if their peer reviewer was accredited by the an OEI, 28% if accredited by the Institute of Osteopath (British Osteopathic Association) and 30% if the peer reviewer was accredited by 'Advanced Practice Groups'. Only 30% said they would be able to bring up problems and tough issues during a peer review conducted in formal discussion with an osteopath accredited as a peer reviewer by the Institute of Osteopathy or Advanced Practice Groups, and even fewer (25%) if accredited by an OEI. Few osteopaths believed that 'Peer review would produce fair outcomes if conducted in formal discussion with an osteopath accredited as a peer reviewer by the Institute of

Osteopathy (23%), Advanced Practice Groups (24%) or an OEI (21%). So again our results suggest osteopaths are wary of formal peer review discussions run, not only by the GOsC, but also by other osteopathic organisations more generally.

An osteopath asked questions about the training peer reviewers would receive:

> *"How many people have got experience of mentoring? Are you going to train your mentors? And there is also an unspoken over-reliance that most of the mentors have come from the OEIs … You have got to have the confidence and the security [in mentors]… knowing that they are not going to shoot you or haul you up in front of something whack, if you kept your mouth shut, you might be alright." 4.14G*

There appeared to be some issues to clarify regarding a potential peer discussion review process.

Summary

In sum, our interview findings suggest that many osteopaths would find discussions with other osteopaths useful, in what we have previously referred to as 'formative spaces'(McGivern and Fischer, 2012). Indeed discussion in formative spaces would provide a mechanism to prevent professional isolation, disengagement and consequent poor osteopathic practice or professionalism among new osteopaths and those who are older and at risk of professional disengagement.

Our survey results point to suspicion among osteopaths of *formal* peer discussion review processes, particularly if peer reviewers are imposed. Our survey data suggests that most osteopaths would be able to discuss problems and tough issues during an *informal* peer review, particularly if osteopaths are able to choose their peer reviewer. While there are risks associated with 'buddy abuse', we believe that, on balance, informal peer review would be at helpful form of peer review for improving osteopaths' practice.

While the evidence from this research supports the introduction of peer discussion review, potential problems may arise around the process being 'documented', as specified in the current proposals. If osteopaths worry peer discussion reviews may be reported to the GOsC, they are less likely to engage in the process, particularly discuss problems and tough issues, which, if unaddressed, may become malpractice. While documentation may helpfully provide structure for peer discussion review (if developed through consultation between the GOsC and osteopathy profession, although it may be useful for osteopaths to reflect on patient feedback and clinical audit) it must be clear that the detailed content of peer discussion reviews will remain confidential, and will not be reported to the GOsC, except in the most serious cases of professional malpractice. As our research suggests, as discussed in relation to patient modesty for example, osteopaths often interpret regulation defensively, in ways that may not be intended by the regulator. If the content of peer discussion reviews did need to be recorded, then osteopaths' ability to choose a peer reviewer they trust and to jointly agree what will be reported would become even more important; osteopaths must be able to openly honestly discuss all aspects of their practice, *particularly* problems, without fearing that doing so puts them at greater risk of being subject to a FtP hearing.

Our survey results suggest that osteopaths are aware of far more potential sub-standard practice and professionalism than they report to the GOsC and tend to deal with this informally (reflecting findings in other professions; see, for example Jones and Kelly (Jones and Kelly, 2014). 28% of survey respondents said that they 'have had concerns about another osteopath's ability to do their job', 41% of these within the past 12 months, with most concerns relating to osteopaths behaviour (70%) or clinical competence (69%). While 59% of these osteopaths 'considered reporting another osteopath for actions that they thought were wrong or unethical', only 10% said that they did report the osteopath to the GOsC, while 11% said they 'spoke to the osteopath in question' and 26% said they 'discussed the osteopath with another osteopath or health professional'. While 82% of survey respondents agreed (only 2% disagreed) that they 'would always report another osteopath to the GOsC for serious

malpractice (e.g. where patients were at risk of serious harm)', 63% agreed that 'unless it is serious, it is better to deal with concerns about another osteopath informally, rather than go through a formal regulatory process' (only 8% disagreed). Thus the informal professional first line of regulation, occurring 'behind closed doors' (Rosenthal, 1995) in a 'formative space' (McGivern and Fischer, 2012) appears to be an important mechanism preventing poor practice and professionalism. We suggest that introducing informal peer discussion review is likely to strengthen this professional first line of regulation.

Questions then arise about how osteopaths should address, and what responsibility osteopaths have for, colleagues they peer review and find to be substandard. As an osteopath commented:

> *"Whose responsibility it is to monitor it? … Are we then responsible for flagging-up that this person didn't know [something to a sufficient standard]? … Do they then have a condition of practice issued to them? ... Anything on the surface is nice and simple but once you actually start to look at it more, it creates ripples. What actually would be the outcome if you thought you observed insufficient practice? … We could make a suggestion… If they refused to do it I suppose we could threaten to call in the GOsC." (5.6 G1)*

As we have discussed elsewhere (see section on experiences of complaints), it may be helpful to think about a 'risk-based' or 'right touch' (PSA 2012) approach to peer review, drawing on the concept of 'red flags' (or 'red cards' or crossing 'red lines'), relating to serious risks associated with osteopaths' practice or professionalism, and 'yellow cards' (or crossing 'yellow lines'), relating to areas where osteopaths' practice or professionalism might be at risk of being slightly or moderately sub-standard. While red flags and yellow flags have specific meanings in clinical terms[16], and so careful thought would is needed about these terms are used, we nonetheless think similar language may useful when thinking about risk-based osteopathic

[16] http://www.physio-pedia.com/The_Flag_System

regulation. Indeed the concept of 'yellow cards' has been used in relation to the reporting of patient safety incidents in pharmacy (Avery et al., 2011).

Our findings suggest that osteopath peer reviewers may be able to address less serious 'yellow cards', and prevent them from becoming serious 'red flags', through a confidential formative professional discussion and only need to report 'red flags' risks to the GOsC, reflecting rules relating to client confidentiality in, for example, psychotherapy and counselling[17] [18]. Previous research (Leach et al., 2011) has highlighted a lack of clarity about when concerns about osteopaths are best addressed informally and when the need to be reported to the GOsC. Peer reviewers therefore need clear guidelines for what constitutes a concern that raises a serious 'red flag', and then use their professional judgement about whether issues need to be given a 'red card' or 'yellow card'. However, as we have noted, it is vital that osteopaths involved in peer discussion review interpret the process as a confidential and informal 'formative space' in which to openly discuss their practice and professionalism, particularly aspects they may worry about.

[17] http://www.bacp.co.uk/ethical_framework/ETHICAL%20FRAMEWORK%20(BSL%20VERSION)/Respectingprivacyandconfidentiality%20.php

[18] http://www.ukcp.org.uk/16/information/43/ethical-principles-and-code-of-professional-conduct

9. Summary, discussion, and conclusions

In this final section we bring the findings of the research project and report together by summarising the findings of the study, discussing their implications, drawing conclusions and making recommendations for osteopathic regulation, OPS, and the GOsC's current proposals for assuring continuing FtP.

Introduction

In the first section of the report, we provided background information about the research project and our approach, reiterating the research questions the GOsC commissioned us to answer, which were:

i) What regulatory activities best support osteopaths to be able to deliver care and to practice in accordance with the OPS?
ii) What factors inhibit osteopaths from practising in accordance with OPS?
iii) What factors encourage osteopaths to practice in accordance with OPS?

In our research proposal, we expanded the research questions to the following:

- How do osteopaths understand *OPS* and judge whether their own practice, and that of their colleagues, complies with these standards?
- Which osteopathic regulatory activities most support or hinder better osteopathic practice, patient quality and safety?
- Which standards are more or less difficult to comply with, and why?
- How do patients and members of the public judge the effectiveness and usefulness of osteopathic treatment and whether it complies with standards?
- How do osteopaths, the public and patients judge the effectiveness of osteopathic regulatory activities and standards?

- Are there any variations in respondents' views, and if so, what accounts for such variations?
- How do wider educational, organisational and regulatory activities affect compliance with standards and effective osteopathic practice?
- How can the GOsC evaluate and demonstrate the effectiveness of its regulatory activities on an on-going basis?

We discussed the policy context in which osteopathic regulation occurs and this study took place, including the development osteopathic regulation, 'revalidation' and the GOsC's current approach to 'CPD providing assurance of continuing FtP'. We noted the nascent nature of osteopathy as a profession, the complex nature of osteopathic practice and its limited evidence-base, which we suggest may make regulation against standards difficult. We discussed theory relevant to clinical professionals and their regulation, including risk-based and 'right touch' (PSA, 2010, PSA, 2012) regulation, and noted a tension between professionals' drive for autonomy and self-regulation and the introduction of external statutory regulation. These themes are discussed throughout the report and we will return to them again here in this final section.

Research methods

The second section of the report described the research methods we used to gather and analyse data for the project. We developed a list of interview questions based on the GOsC project specification, two literature reviews we conducted about osteopathic practice, the osteopathy profession and its regulation (see Appendix 1) and professionalism, health professional regulation, revalidation and continuing fitness to practice more broadly (see Appendix 2), and analysis of the GOsC documentation.

After receiving research ethical approval for the project, we conducted semi-structured interviews with 55 osteopathic regulatory stakeholders, including 37

osteopaths, representatives of OEIs, osteopathic groups and constituencies, osteopathy patients, GOsC staff, people in FtP roles in other health professional regulators, a representative from the Law Commission, a news producer and politician. We analysed these narrative interview data using thematic and inductive coding, template and thematic analysis. We present and discuss exemplar interview narrative extracts in this report to illustrate findings.

To triangulate and test the wider empirical generalisability of interview data, we also conducted an online survey, which 809 osteopaths completed, equating to a 17% response rate from approximately 4900 osteopaths on the GOsC register at the time. We analysed responses to our survey examining the percentage of respondents agreeing and disagreeing with statements and responding to other questions. We ran T-tests for statistically significant differences between the responses to questions among demographic groups. We also conducted an exploratory factor analysis for a covariance between responses to questions indicating aggregate factors. We discuss the survey analyses throughout the report and again below.

Osteopathic professional Identity, practice and evidence-base

In the third section, we began to discuss empirical findings, here relating to osteopaths' perceptions of their profession, professional identity, osteopathic practice and evidence relating to osteopathic risks and effectiveness. Before examining how regulation affects professionals and their practice, it is important to understand who these professionals are and what their practice is.

Interviewees described osteopathy as a 'broad church'; containing osteopaths using approaches ranging from quasi-medical structural musculoskeletal manual therapy to esoteric healing. Some osteopaths we interviewed argued that osteopathy was distinctive from other manual therapies (such as physiotherapy and chiropractic), whereas others believed there was significant overlap between these professions. Being an osteopath and helping patients was an important part of most osteopaths'

identities. Interviewees also noted that practising as an osteopath commonly involved running a small business. While osteopaths have an interest in improving the collective quality and reputation of their profession, they also compete for patients with other osteopaths and manual therapists, which may create a disincentive to collaborating and openly discussing their practice with them. For many osteopaths, being able to work independently (outside large organisations) was important and is one of the reasons why they trained as an osteopath rather than another clinical professional (like a physiotherapist, working in the NHS).

84% of osteopaths agreed 'osteopathy is a unique health care profession' (only 8% disagreed) and 55% agreed that 'I see myself as an osteopath first, and then as a health care professional' (22% disagreed). Our exploratory factor analysis of survey data indicated an aggregate Factor (7) relating to 'osteopathic distinctiveness', with a mean response of 3.93 (where 5 equates to strongly agreeing and 1 strongly disagreeing with osteopathic distinctiveness). Survey data suggests that osteopaths predominantly believe in the distinctiveness of their profession.

Osteopaths we interviewed commonly described their practice as holistic and patient-centred, emphasising the importance of 'hands on' diagnosis and treatment ('palpation') and communication between osteopath and patient. While osteopaths appear to draw upon their scientific osteopathic training and associated models, a major element of osteopathic practice is subjective and intuitive.

Osteopaths noted the limited evidence-base relating to the efficacy and risks associated with osteopathy. While most osteopaths were in favour of evidence-based practice in principle, fewer were positive about its effects in practice. Some worried over-emphasis on evidence-based practice could undermine important aspects of osteopathic practice (as noted earlier, related to osteopathy being a holistic, 'hands-on', relational, subjective and intuitive practice).

Most osteopaths we interviewed believed that the complex nature of osteopathic practice meant that it was less amenable to traditional biomedical approaches to

research and the development of evidence. So while more osteopathic research was needed, it needed to be carried out in appropriate ways reflecting osteopathy rather than medicine.

Our exploratory factor analysis indicated an aggregate factor (4), relating to being 'pro-evidence-based practice', with a mean response of 3.29 (5 in strongly in favour, 1 strongly against). So on balance osteopaths seem marginally 'pro-evidence-based practice'. Men and more recently graduated osteopaths were significantly more pro-evidence-based.

In sum, the complexity of osteopathic practice, its limited evidence-base, and the varied and independent nature of osteopathic practice mean that regulation against standards may often be difficult, based upon judgement and interpretation, as discussed below.

Perceptions of the Osteopathic Practice Standards

In the fourth section, we discussed osteopaths' perceptions of osteopathic practice standards (OPS).

Many osteopaths agreed the OPS provided a useful 'benchmark' for good practice but others had concerns about judging complex osteopathic practice against abstract standards. 44% of osteopaths responding to our survey agreed that 'the OPS reflect what it means to be a good osteopath' (21% disagreed). Some interviewees were critical of the OPS for being too oriented towards patient safety rather than efficacy 26% agreed that 'complying with the OPS restricts my ability to provide care that I believe would benefit patients', although more (37%) disagreed. 38% agreed that 'the OPS should put greater emphasis on clinical effectiveness rather than clinical safety'. Many osteopaths believed the OPS were too rigid, bureaucratic or legalistic (58% agreed 'The OPS reflect an overly legalised view of osteopathy'; only 14%

disagreed), while others simultaneously complained about OPS being too vague and open to interpretation.

Few osteopaths we interviewed were able to articulate how they judged their own or colleagues' practice against OPS, describing instead a sense or a feeling. 49% of osteopaths in our survey agreed that they 'have a clear sense of whether I am complying with the OPS while practising as an osteopath' (18% disagreed). Some osteopathic interviewees said that they were 'always' or 'constantly' thinking about the OPS while treating patients, particularly recording patient consent. Others said they thought about them 'unconsciously' in 'the back of their mind', while a few commented that they were driven by their training and patients rather that the OPS. Judging the extent to which the OPS influence osteopaths' practice is therefore difficult. 45% agreed 'What I do as an osteopath always fully complies with all the OPS' but 19% disagreed; meaning that one in five osteopaths believes that they do not always comply with the OPS.

Our exploratory factor analysis of survey data indicated a factor (3) relating to 'Feeling Compliant with Standards', signalled a co-variance between osteopaths' responses to survey questions about: 'being aware of the OPS'; agreeing the osteopaths' practice 'always complied with the OPS'; having a clear 'sense' of compliance but which would be 'difficult to demonstrate'; and saying that 'complying with the OPS restricted their ability to provide care… that would benefit patients'. The mean response for this factor was 3.34 (where 5 indicates strongly agree and 1 strongly disagree) suggests osteopaths feel more compliant than not with the OPS. We found no significant associations between factor 3 and demographic criteria.

Osteopaths were almost twice as likely to agree that they complied with the OPS 'to avoid getting into trouble with the GOsC' (49%) or 'to protect themselves from being sued by a patient' (54%) than because the OPS 'reflect what it means to be a good osteopath (28%). Our factor analysis also indicated a factor (6) relating to 'fear-based compliance with regulation', signalling a co-variance between complying with the

OPS out of 'fear of getting into trouble with the GOsC', to avoid 'being sued by a patient' or out of 'fear of what the GOsC could do to' osteopaths. The mean response for this factor was 3.32 (5 strongly agree, 1 strongly disagree), suggesting osteopaths comply with the OPS out of fear to some extent. Our factor analysis indicated that 'fear-based compliance with regulation' was significantly more likely among more recently qualified osteopaths.

Osteopaths we interviewed, particularly those working alone, complained about three sets of standards in particular. First, relating to informed consent and communicating risks. Some osteopaths criticised these standards for being more driven by abstract legal requirements than osteopathic practice, where risks were small and unknown, so communicating risks to patients was unnecessary and likely to scare patients and undermine their confidence in osteopathy. Other osteopaths (particularly those working in OEIs) were less concerned about these standards, noting *ways* of communicating risks and gaining consent that avoided problems. While the GOsC has attempted to address concerns relating informed consent and communicating risks in its revised OPS, and recent material it has provided about communicating risks, there seems to be more need for training among many osteopaths about communicating risks and gaining consent from patients.

The second set of standards osteopaths criticised relating to note-keeping. Some commented that osteopaths were more often admonished for poor note-keeping than for poor practice, while clinical scandals (e.g. relating to Shipman and Mid-Staffordshire NHS Trust), showed that record-keeping did not necessarily reflect good practice. More significantly, osteopaths worried that their notes might be later (mis)interpreted in a GOsC FtP hearing, as we will discuss more below.

The third standard osteopaths particularly complained about related to patient modesty. These complaints are analytically interesting because the OPS specify that osteopaths must 'respect patients' dignity and modesty' and be 'sensitive' to their needs and reactions. However, some osteopaths we interviewed interpreted modesty-related standards in black and white terms; for example, as specifying that

osteopaths must never remain in the room while a patient is undressing, regardless of circumstances like elderly patients needing help. As a consequence they chose to ignore standards relating to modesty and dignity because they perceived them as 'stupid' or 'pointless' rules, instead using their professional judgement about individual patients' reactions to modesty. Thus osteopaths who believed they were ignoring what they perceived to be 'stupid' standards may actually be complying with them in the sense they were intended.

So what explains osteopaths' interpretation of standards in this way? One osteopath we interviewed described how a colleague had been admonished in a FtP hearing for "not offering a patient a towel" to cover themselves with during a consultation. Such stories fearfully and anxiously frame how some osteopaths interpret safe compliance with standards, in reaction to an imagined potential FtP hearing in future. This may illustrate the way stories osteopaths hear about FtP hearings and regulation produce anxiety that distorts their perceptions of the standards' original intension and effects how they are enacted in practice.

OEIs appeared to play a significant role in getting trainee osteopaths to internalise the OPS, which one interviewee described as being "drip fed into their psyche". OEIs' curricula are mapped against the OPS. OEIs also run exercises and provide tutor support to help students make sense of what the OPS mean in day-to-day practice. Our analysis of survey data indicated that more recently qualified osteopaths are significantly more likely to demonstrate 'fear-based compliance with standards' (Factor 6) and to believe the 'OPS reflect what it means to be a good osteopath' and that 'osteopaths should be regulated by law'. These attitudes towards the OPS and osteopathic regulation may be a consequence of having more recently learned about them in an OEI.

In sum, many osteopaths believed the OPS were a good 'benchmark' to compare their practice against and OEIs seem to play a significant role in getting new osteopaths to internalise the OPS. However, some complained the OPS were too vague, while others criticised them for being too rigid. Standards relating to

communicating risks to patients, note keeping and patient modesty were particularly criticised. Many osteopaths appear to comply with the OPS to avoid getting into trouble. Some osteopaths said they always thought about and followed the OPS, others believed they followed the OPS unconsciously. However, from in our survey, one in five osteopaths seems to disagree that they always comply with the OPS. Yet judging whether osteopaths comply with the OPS was seen to be difficult, based more on a 'sense' than hard evidence, and therefore assessing the extent osteopaths overall comply is more difficult still.

Perceptions and experiences of the GOsC and regulation

In the fifth section, we examined osteopaths' perceptions and experiences of the GOsC and regulation more generally. As Quick's (2011: 3) review of literature on the impact of health professional regulation notes: 'the clear message to emerge from a number of studies is that regulation (however well intended) is far more likely to be complied with when accepted as legitimate by practitioners.' Therefore positive perceptions of the GOsC and osteopathic regulation are likely to have beneficial knock on implications for compliance with the OPS.

Many osteopaths we interviewed, particularly those in contact with the GOsC, commented on how much the GOsC had improved in the last four or five years, largely due to the GOsC staff reaching out and personally engaging with the osteopathy profession. These osteopaths also appeared more likely to agree that the GOsC and OPS were legitimate and that osteopaths should comply with osteopathic regulation and standards.

Past difficult relations between the GOsC and the osteopathy profession continued to cloud some osteopaths' perceptions of the GOsC however. If some osteopaths' historical experiences led them to doubt that the GOsC understands osteopathic practice, this may have knock-on implications for their views of the legitimacy of compliance with the OPS.

Interview data and survey data about perceptions of standards suggest that more recently qualified osteopaths might be positive about the GOsC. However, our exploratory factor analysis indicated an aggregate factor (5) relating to being 'pro-GOsC' (mean 2.99, where 5 is strongly agree, 1 strongly disagree) but found no significant association between this factor and time qualified as an osteopath. The only group significantly less 'pro-GOsC' were osteopaths working alone.

Our exploratory factor analysis of survey data indicated two Factors (8: 'Experiential perceptions of the GOsC', and 10: 'Narrative perceptions of the GOsC'), with mean responses of 3.73 and 3.02 respectively (5 strongly agree, 1 strongly disagree). Osteopaths' perceptions of the GOsC seem most affected by what the GOsC communicates (73%), osteopaths' experiences of the GOsC (65% agreed) and what they hear about the GOsC from colleagues (60%). We found a correlation between time qualified as an osteopaths and 'experiential perceptions of the GOsC' (Factor 8); so longer qualified osteopaths' perceptions of the GOsC are more affected by experiences of the GOsC and the GOsC's communications.

We also discussed the ways in which the media and politicians frame and develop regulation in responses to cases of 'one bad apple' and the government's need to be seen to 'do something' rather than more rational analysis of how to develop effective forms of regulation. This finding reflects previous accounts of 'tombstone regulation' (Hood et al., 2004) developed as 'Pavlovian regulatory responses' (Hood and Lodge, 2005) to 'spectacular' professional malpractice (McGivern and Fischer, 2012). At the sample time, professions can be isolated from wider societal norms and expectations of professional regulation. Regulators therefore need to interpret regulation to make it applicable, relevant, workable and effective for the professionals they regulate.

In sum, many interviewees commented on how much the GOsC had improved in recent years, although the perceptions of some were still clouded by historical problems between the GOsC and the osteopathy profession. However, we found no

association between time qualified as an osteopath and a factor relating to being 'pro-GOsC'. We suggest that overall perceptions of regulators may affect how people perceive and comply with standards. In our survey, most osteopaths agreed that their perceptions of the GOsC were affected by the GOsC's communications, their experiences of the GOsC and by what they heard from professional colleagues.

Experiences and perceptions of Fitness to Practise hearings

In the sixth section, we discussed one patient's and two osteopaths' experiences and perceptions of FtP hearings, and ways in which such experiences affect how the wider population of osteopaths perceived FtP and regulation. While FtP hearings were seen to be well managed and fair, neither the patient nor the osteopaths involved described them as producing satisfactory outcomes. This was, in part, due to the complexity and ambiguity associated with interpreting whether osteopaths' practice complies with the OPS. While our findings are based upon a small number of interviews, they reflect research conducted for the GOsC by Moulton Hall Ltd (see Annex B to Item 4 of the report to the Osteopathic Practice Committee, 2 October 2014) and Leach and colleagues (2011). Our survey data also suggests that few osteopaths (23%) 'are confident in the GOsC disciplinary procedures to produce fair outcomes', with osteopaths who had been subject to complaints made against them to the GOsC, significantly *less* likely to agree with this statement (mean 2.72 vs 2.96).

These data point to the risk of osteopaths involved in FtP hearings perversely becoming *less* engaged with osteopathy and osteopathic regulation as a consequence of their experience. Evidence suggests that doctors who have had a previous complaint made against them to the GMC are *three* times more likely to be subject to a future complaint, and doctors with two or more complaints against them are *seven* times more likely to be subject to a future complaint (GMC Annual

Report, 2014)[19]. Research from Australia (Bismark et al., 2013) and the USA also suggests that those subject to complaints are significantly more likely to have received subsequent complaints (Papadakis et al., 2008). Legislation framing osteopathic regulation gives the GOsC a statutory responsibility to investigate complaints made about osteopaths and provides the GOsC (unlike other regulators such as the GMC) with little leeway in terms of how it addresses complaints. However our findings suggest that peer discussion review within the process to demonstrate continuing fitness to practice may more proactively prevent malpractice than formal FtP hearings.

We also describe how experiences, perceptions and stories of unfair and damaging FtP hearings circulate within the osteopathy profession. These fuel osteopaths' anxiety about being caught up in a FtP hearing, regardless of the quality of their practice or professionalism and innocence and may lead to defensive practice. Our findings suggest that preventing FtP hearings for all but the most serious allegations may be advantageous, particularly in light of how osteopaths said problems could be better dealt with and prevented through informal professional processes, as we will discuss further below.

In sum, the GOsC have a legislative duty to investigate complaints made against osteopaths. However, the two osteopaths we interviewed who had been subject to FtP hearings described emerging from the process cynical about regulation, less professionally engaged, and consequently, perhaps, at risk of further complaints about malpractice or poor professionalism. Stories about damaging FtP processes may also produce anxiety and defensive practice within the osteopathic profession more broadly. Our survey results also suggest a low level of confidence in FtP hearings, particularly among those subject to a complaint.

Dealing with problems, near misses and complaints in practice

[19] http://www.gmc-uk.org/SOMEP_2014.pdf_58053580.pdf and http://www.gmc-uk.org/SOMEP_2013_web.pdf_53703867.pdf (see p87).

In the seventh section, we examined osteopaths' experiences of dealing with problems, near misses and complaints in their own and colleagues' practice. 22% of osteopaths in our survey said that they 'had worried that things I have done as an osteopath may not comply with the OPS', so these experiences were relatively common and more common than the number of cases referred to the GOsC.

Some osteopaths we interviewed described how they had learned from problems and near misses. Interviewees suggested that reflection, communication, learning and sharing with other professionals were the most important means for dealing with problems and near misses, which is worrying for an independent and 'lonely' profession like osteopathy, where many osteopaths practise alone. In our survey most osteopaths who had worried about complying with the OPS said that they 'reflected in the issue' (88%), 'spoke to another osteopath or health care professional about the issue' (65%) or read up about the issue (56%) or said they 'read the OPS relevant to the issue' (49%). Few (14%) contacted the Institute of Osteopathy (BOA) or the GOsC (7%) for advice. Longer qualified osteopaths were significantly more likely to 'speak to another colleague' or 'read the OPS relevant to the issue' and significantly less likely to 'not take action'. Male osteopaths and osteopaths working alone were least likely to speak to a colleague if they were worried their practice might not comply with the OPS. More discussion between osteopaths would seem to be useful in helping osteopaths address actual and potential problems in their practice.

We also examined osteopaths' perceptions and experiences of dealing with colleagues they were concerned about. 28% of osteopaths in our survey said that they had 'had concerns about another osteopath's ability to do their job', 41% of these within the past 12 months, so again such concerns were relatively common. Longer qualified osteopaths and those working with others were (perhaps unsurprisingly) most likely to have had concerns.

82% of osteopaths responding to our survey said they 'would always report another osteopath to the GOsC for serious malpractice' (e.g. where patients were at risk of serious harm) and very few (only 2%) disagreed. Interviews also said that they would report 'serious' breaches of malpractice (involving sexual abuse, serious criminality or potential harm to patients). However doubts about the robustness of evidence their concerns were based upon (often hearsay) and concern about making the lives of colleagues already in troubles even more difficult meant that osteopaths were often reluctant to make formal complaints to the GOsC. Thus there appears to be more potential poor osteopathic practice or professionalism than is reported to the GOsC.

Of the osteopaths who said they had been concerned about another osteopath's ability to do their job, only 20% indicated they had reported the osteopath (10% to the GOsC, 5% to the Institute of Osteopath [formerly the British Osteopathic Association] and 5% to the osteopath's employer). 11% said they spoke to the osteopath in question, 26% advised a patient, and 26% discussed the issues with other osteopathic colleagues. 19% decided their concern was not serious or just did nothing. So the data suggests osteopaths prefer an informal approach (speaking with colleagues they knew, or encouraging patients affected to complain about osteopaths they did not know) to dealing with concerns about colleagues. Indeed 63% of the osteopaths responding to our survey agreed that 'unless it is serious, it is better to deal with concerns about another osteopath informally, rather than go through a formal regulatory process' (only 8% disagreed).

Reflecting the findings of interviews, the three main reasons for not reporting colleagues given in our survey were that 'my concern would have been impossible to prove' (53%), 'the issue was resolved' (37%) and 'I did not want to cause trouble' (36%). More recently qualified osteopaths appeared less likely to report colleagues, perhaps because of feeling insecure about their own practice and position within the osteopathy profession. Osteopaths who had had complaints made against them were significantly *more* likely to have had concerns about other osteopaths' abilities

to do their job, but were also significantly *less* likely to have not reported them because 'the issue was resolved.

We can compare these findings relating to osteopaths reporting concerns with colleagues practice with Firth-Cozens and colleagues' (2003) research on doctors' and nurses', upon which some of our survey questions were based. The three main reasons doctors gave for not reporting poor care were that their 'concern would have been impossible to prove', that they 'feared retribution' and 'did not want to cause trouble'. For nurses the three main reasons were they 'feared retribution', 'would not have been listened to' and 'did not want to cause trouble'. So while osteopaths and doctors both did not report concerns because they would have been impossible to prove, relatively few osteopaths were put off reporting colleagues by fear of retribution.

In sum, concerns about osteopaths' own and colleagues' practices appeared relatively common. In our survey, more than one in five osteopaths said they had worried about not complying with the OPS. More than one in four reported having had concerns about an osteopathic colleague. Few of these concerns appear to have been reported to the GOsC. Osteopaths appear to deal with concerns informally. Reflection, learning, communication and sharing with osteopathic colleagues were described as key mechanisms for maintaining high quality practice. Yet osteopathy is described as a 'lonely' profession where such opportunities are lacking for many osteopaths.

Strengthening professionalism by creating 'formative spaces' in 'peer discussion review'

In the final empirical section, we explained how facilitating discussion among osteopaths in 'formative spaces' (McGivern and Fischer, 2012) might improve osteopathic practice, osteopaths' perceptions of 'peer discussions review' and how the process could be most effective.

The Health and Care Professions Council (HCPC) is currently engaged in research with Canadian Professor, Zubin Austin, whose earlier work[20] suggested that 'competency drift' results from clinicians getting bored, isolated, disengaged and stopping caring about their work. The HCPC is exploring ways to develop 'proactive regulation' to identify and prevent 'professional disengagement' and 'competency drift' among the professionals by promoting 'challenging' and reflective 'conversations about professionalism' among professionals to 'prevent small problems becoming big ones'[21].

Similarly many osteopaths we interviewed suggested that osteopathy needs to develop a 'no blame culture', provide support mechanisms to help osteopaths in difficulties, and training to help osteopaths have 'difficult conversations' relating to concerns about colleagues. Given the findings of our research on osteopaths, and evidence (Bismark et al., 2013, Papadakis et al., 2008)(GMC Annual Report, 2014)[22] suggesting that formal complaints processes often do little to reengage problem doctors and prevent future complaints, we take the view that promoting conversations about professionalism among professionals themselves, in what we have described as 'formative spaces' (McGivern and Fischer, 2012), may be an effective form of proactive regulation.

A key part of the GOsC's proposals for 'CPD providing assurance of continuing FtP' is the introduction of 'peer discussion review' involving a discussion about osteopaths' practise with another osteopath every three years. 'Peer discussion review' appears to support reflective practice and communication between osteopaths, which, as noted in the previous section, emerged as key mechanisms supporting safe and effective osteopathic practice. A few osteopaths we interviewed received clinical

20 http://www.hpc-uk.org/assets/documents/10004605EducationUpdate-Issue16-May2014-e.pdf see page 6

21 http://www.hpc-uk.org/assets/documents/10004605EducationUpdate-Issue16-May2014-e.pdf see page 6

22 http://www.gmc-uk.org/SOMEP_2014.pdf_58053580.pdf and http://www.gmc-uk.org/SOMEP_2013_web.pdf_53703867.pdf (see P.87)

supervision, which they described as very useful. Some osteopaths described working in isolation and wanting opportunities to share, learn and 'off-load' with colleagues. Most osteopaths we interviewed agreed that more conversations with colleagues could be helpful.

While in our survey only 34% of osteopaths agreed 'peer review would have a positive effect on how I practise as an osteopath, as part of the GOsC process to provide assurance of continuing FtP', more than half (52%) agreed that 'peer review, involving *informal* discussion of my practice with another osteopath, would have a positive effect on how I practise as an osteopath'. 69% agreed they 'would be able to bring up problems and tough issues during a peer review involving *informal* discussion of my practise with another osteopath'. Our factor analysis of survey data indicated two factors relating to 'favouring formal peer review' (Factor 1) and 'favouring informal peer review' (Factor 2), with mean responses of 2.57 and 3.26 respectively (5 indicates strongly agree, 1 indicates strongly disagree). On balance, while a minority of osteopaths favour formal peer review the majority appear to support *informal* peer review in which they chose their own peer reviewer.

More recently qualified osteopaths were significantly more likely to agree that 'peer review, involving informal discussion of my practice with another osteopath would have a positive impact on how I practise as an osteopath'. Female osteopaths appear more likely to say they would bring up 'tough issues and problems' during peer review and that 'maintaining my GOsC registration helps me reflect on my practice'. However osteopaths working *alone* appear, from our factor analysis of our survey data, *less* positive about both formal (Factor 1) and informal peer review (Factor 2). So, while osteopaths practising alone may benefit most from more discussion with osteopaths, they are the group that need to be most persuaded that it would be advantageous.

There are some issues the GOsC will need to address in order for peer discussion review to work more effectively. First, some osteopaths raised concerns about 'peer

discussion review' becoming 'a coffee with your mate'. Peer reviewers may therefore need training and a structure for conducting peer reviews.

Second, the GOsC's proposals for peer discussion review suggested that they would be recorded. Our research suggests that many osteopaths are wary of the GOsC and being involved in a formal investigation or FtP hearing. Recording the content of peer discussion reviews risks undermining osteopaths' willingness to engage with the process and openly discuss any tough issues and problems they may be facing in their practice. We therefore suggest that the detailed content of peer review discussions should remain confidential. Recording of peer discussion reviews should be agreed by osteopaths and their peer reviewers. Records should be limited to noting when the process has taken place, by whom, confirming that the discussion followed a structure and covered key issues facing osteopaths' practice or provide a high level overview of the discussion (as agreed by the GOsC and osteopathy profession), note developmental action points, and that no 'serious concerns' were raised. Osteopaths should only disclose issues discussed during peer discussion reviews if they raise a *serious* risk (as we will explain further below). The approach to recording and confidentiality could perhaps draw on an approach used for psychotherapists and counsellors, who must maintain client confidentiality except where clients disclose issues that put themselves or others at serious risk, and in such cases they must inform their client of their intention to do so[23] [24].

The majority of osteopaths seem to support the introduction of informal peer reviews and believe that it would help improve their practice, although osteopaths who practise alone are less supportive of the process. There is the strong evidence from this research of the importance and efficacy of discussion among osteopathic peers and yet osteopaths are often isolated from professional colleagues with few such opportunities for reflective discussion. We therefore suggest that osteopaths

[23] http://www.bacp.co.uk/ethical_framework/ETHICAL%20FRAMEWORK%20(BSL%20VERSION)/Respectingprivacyandconfidentiality%20.php

[24] http://www.ukcp.org.uk/16/information/43/ethical-principles-and-code-of-professional-conduct

informally discuss their practice with a colleague of their choice *on an annual basis,* rather than every three years as currently proposed by the GOsC. This would also encourage osteopaths in thinking about peer discussion review as a developmental professional process, not simply something they need to do to complete the paperwork relating to their professional registration. The documentation relating to such discussion (subject to the caveats relating to anonymity we have discussed) could be submitted every three years, in line with the GOsC proposals for peer discussion review.

Proactive risk-based 'right touch' osteopathic regulation based on 'red flags' and 'yellow cards'

Osteopaths we interviewed used the language of 'yellow cards' and 'red flags' in relation to problematic osteopathic practice and professionalism. The concept of 'yellow cards' has been used to promote patient safety in relation to the reporting of adverse reactions to pharmaceuticals (Avery et al., 2011). Thinking about concerns about osteopaths' practice or professionalism in this way may be useful too, while carefully considering their specific meanings in clinical terms[25] so that the intent of such regulation is clear. The process would also need to address concerns about clinical professional regulation as discussed in recent policy documents (Department-of-Health, 2011). 'Red flags', 'red cards' or crossing 'red lines', where osteopaths pose a serious danger, would need to be reported the GOsC, require formal investigation and FtP hearings to protect patients and the public.

However, given the problems with FtP hearings we have noted, and the complexity and limited efficacy of dealing with 'information problems' (Ogus, 1995) associated with evaluating osteopathic practice, 'yellow cards', relating to less serious concerns about osteopaths, may be better addressed *informally* between professionals during peer discussions reviews. One-to-one peer discussions between osteopaths may

[25] http://www.physio-pedia.com/The_Flag_System

provide 'relational authority' (Huising, 2014) more able to elicit open information from osteopaths and produce improvements in practice and professionalism. This can be seen as providing a form of 'intelligent accountability' (Roberts, 2009) or 'narrative accountability' (Levay and Waks, 2007) among professional peers. Previous research (Leach et al., 2011) has highlighted confusion about when concerns about osteopaths should be addressed informally and when they need to be formally reported to the GOsC. Osteopaths conducting peer discussions reviews need clear guidance about what constitutes a 'red flag' and 'yellow card' and then make a professional judgement about what and when to report concerns.

The PSA Report on 'An Approach to assuring continuing fitness to practise based upon right-touch regulation' (2012) suggest that health professional regulation should be risk-based, taking an approach that balances the risk of over-regulation and under-regulation, in a way that is relevant to the quantified risks relating the professionals being regulated. The report notes that regulation should be as simple as possible, used only when necessary, may have unintended consequences and that any problems should be dealt with as close as possible to where they occur. The Report acknowledges that the culture in which professionals practice and wider notions of professionalism frame how professionals respond to regulation and the problems regulation is designed to address. Subject to the provisos we have discussed above about anonymity, recording discussions and training for peer reviewers (including about how to have 'challenging conversations'), our findings broadly support the GOsC approach to CPD and 'peer discussion review' providing assurance of continuing FtP as a 'right touch' (PSA 2010; 2012) approach to professional regulation.

We suggest that the idea of 'red flags' and 'yellow cards' may also be a useful risk-based way of thinking about how to address concerns about osteopaths and their practice. Previous research (Leach et al., 2011) has noted that some complaints made to the GOsC would have been better addressed through informal mechanisms. Serious concerns ('red flags') need to be reported to the GOsC whereas less serious

concerns ('yellow cards') may be better addressed developmentally between osteopaths in 'formative spaces' within 'peer discussion reviews'.

Reflecting the Report on the Inquiry into the Mid Staffs Scandal (Francis, 2013), the PSA Report (2012) also expresses an aspiration for regulation to be 'agile' and 'proactive', looking forward to prevent problems before they occur, rather than retrospectively dealing with professional problems after they have happened. Osteopathic regulation could become more 'agile' and 'proactive' by following an example from the aviation industry (which some osteopaths mentioned osteopathy could learn from) and introduce anonymised reporting of potential patient safety issues, such as CHIRP[26]. This would allow the profession and the GOsC to get a better sense of the issues facing osteopaths and develop 'participative networks' addressing them. Discussing what health care might learn from the aviation industry, McRae (McRae, 2008: 66) notes:

'By organizing participation, regulators can influence attitudes, beliefs, attention, motivations and knowledge about safety, as well as policy, procedures and protocols. The 'softer' features of organizational life are hard to control directly, and are a persistent challenge for regulators. Organizing participation in incident-reporting systems may provide one way of reaching these softer, and harder to reach, aspects of organizational life, allowing regulators to shape the culture of organizations.'

Could the GOsC introduce a system similar to CHIRP for *anonymously* reporting 'yellow cards' raised during peer discussion review? This might enable the GOsC and wider osteopathy profession to become more aware of and able to address problems osteopaths face in their practice.

Relational regulation and engaging with the osteopathy profession

[26] https://www.chirp.co.uk/

The General Medical Council have a 'four layer model' [27] (GMC, 2005) of medical regulation in which professionals are regulated by themselves as a professional, by the teams they work in, by their employer and by the professional regulator (also see Quick 2011). The independent nature of most osteopaths' practice means that there are only two layers of regulation, involving the osteopathy profession and the GOsC. An interviewee from GOsC noted: *"for the majority of the osteopaths... It is them and us, and so there needs to be that closer relationship." (9.5G)*

Our research supports the GOsC's relational and engaged approach to regulating osteopaths. Osteopaths perceive the GOsC to have significantly improved in recent years. In part, this is because the GOsC has proactively and personally engaged with osteopaths. Consequently, osteopaths know and understand the GOsC better and are more inclined to accept the legitimacy of the OPS. Engagement between the GOsC and the osteopathy profession may be changing the stories osteopaths tell their colleagues, which frame how osteopaths perceive the GOsC and consequently react to OPS, improving levels of compliance. Trust, good communication and relations between the GOsC and osteopaths are an important frame within which CPD and peer discussion review can provide assurance of osteopaths' continuing FtP. The more osteopaths perceive the process to reflect good osteopathic practice, understand and trust its aims, the more they are likely to engage and improve their practice.

'Macromanagement' (Huising and Silbey, 2011) and 'self-policing' (Foucault, 1979) by osteopaths themselves within 'formative spaces' constructed and managed by regulators, may be more effective than forcing standards and regulation upon professionals. Research on professional regulation (Quick, 2011, McGivern and Fischer, 2012, Scraggs, 2012) and recent events at Mid-Staffordshire NHS Trust have

27 http://www.gmc-uk.org/4d_Developing_Riskbased_Regulation_Progress_Reportannex_A.pdf_25398949.pdf (see p3)

shown[28] that disengaged professionals often ignore and by-pass formal and mandated processes. From descriptions of FtP hearings we heard, formal FtP processes rarely seem to lead to satisfactory or constructive outcomes. Huising and Silbey (2011) argue that there is inevitably a gap between regulatory standards and compliance in practice. This is particularly likely given the complexity of osteopathic practice, limited evidence relating to its efficacy or risks, the independence of osteopaths, and the need for interpretive judgements about whether practice complies with OPS. However this gap may be best reduced through 'relational regulation' (Huising and Silbey, 2011).

Discussing relational regulation, Etienne (2011, 2013) suggests that regulators need to attend to multiple regulatory 'signals', operating in the foreground and background, and align the hedonic (feeling), normative (ethical), and gain (financial, free time etc.) incentives for regulatory compliance. To apply Etienne's ideas in the context of osteopathic regulation, osteopaths may, for example, agree with normative (ethical) and gain (benefit to practice) incentives signalled by the GOsC in the foreground, supporting open and reflective participation in regulatory processes. However, osteopaths may not engage with these processes due to louder hedonic (fear/anxiety) signals in the background, sent by stories about damaging professional experiences in FtP hearings. The GOsC may want to consider how it can best align the signals it sends so that hedonic, normative and gain incentives support compliance with the OPS.

There is growing evidence that professionals are more likely to comply with regulation and standards (Scraggs, 2012, Quick, 2011, McGivern and Fischer, 2012, Solicitors-Regulation-Authority, 2011), as well as clinical guidelines (Garfield and Garfield, 2000, Currie et al., 2009, Ferlie et al., 2011, 2012, 2013, Ferlie and McGivern, 2014, McGivern et al., 2015), when they feel professionals have been involved in developing them, they understand the evidence behind them and believe that they reflect or even lead to improvements in legitimate clinical practice.

[28] http://www.midstaffspublicinquiry.com/

Compliance with accountability mechanisms is affected by the values, beliefs, cultures, attitudes, perceptions, resources and capabilities of those involved (Cleary et al., 2013). As Currie and colleagues note: 'regulatory and surveillance mechanisms will only be effective where their intent converges with the behaviours of professionals in exercising clinical judgement' (Currie et al., 2009: 132-3). Our research reflects this view; that professionals are more likely to comply with regulation they believe is legitimate and will lead to improvements in practice.

Limitations, further research and final thoughts

Our research is based upon what osteopaths *said* about regulation and their practice. We cannot know for sure that this reflects what they actually *do* or what the impact of formative approaches to assuring continuing FtP will be, although we suggest that the nature of 'truth' and 'reality' is always contingent. However 'reactivity' produced by regulation may be as important as the accuracy of evidence the approach it is based upon (McGivern and Fischer, 2012). New ways of understanding behaviour can be 'an engine, not a camera' (MacKenzie, 2008) and 'regulatory innovation' towards better regulation requires taking the risk of doing something new (Black et al., 2005). While we believed the evidence from this study is robust, and supports the formative approach the GOsC is proposing to assure osteopaths' continuing FtP, we also suggest that it may produce positive reactivity.

McGregor's (1960) classic 'Human Relations' ideas about 'Theory X' and 'Theory Y' organisations, which informed much contemporary management thinking, suggest that formative and trust-based approaches tend to produce trustworthy behaviours, motivation and improvement in practice. Formative peer discussion reviews are accordingly more likely to promote behaviour leading to improvements in osteopathic practice and professionalism. Furthermore, our interview and survey data suggest that 'peer discussion review' builds on existing osteopathic practice. Osteopaths seem to deal with all but the most serious problems and concerns *informally* anyway. They also believe that reflective discussions between

professional peers are the best way of addressing them. Encouraging and supporting osteopaths to regulate themselves through regular professional conversations is like pushing at an open door; enforcing external regulations osteopaths neither understand, trust, believe legitimate, effective or reflect osteopathic practice, is like trying to break down a door that is locked shut.

While it is ultimately the Professional Standards Authority's role to evaluate the GOsC's approach to regulating osteopaths, more research is needed to evaluate its impact, how and why this came about, and how osteopathic regulation could be improved. This future research may drive further regulatory innovation. By being explicit in our research methods and our findings, this research may provide a foundation for this future research. Our study could provide the basis for a future 'theory driven' evaluation (Chen, 2004), using the ideas we have developed here to explain in more detail how and why regulation has an impact and could be improved. Alternatively future research could take the form of a 'realist evaluation' (Pawson and Tilley, 1997), explaining the interrelationship between the regulatory mechanism, its context and outcomes.

Our data indicates that the difficulty of demonstrating good standards of osteopathic practice, contested judgements and interpretations of osteopathic practice and professionalism, and limited evidence about osteopathic risks and efficacy is a source of anxiety and insecurity for some osteopaths. Regulatory processes demonstrate and maintain the legitimacy of osteopathic practice, which may help address this anxiety and insecurity. While the risks associated with osteopathy are significantly less than those posed by doctors (PSA, 2012), osteopathy's benefits are also less well established. Patients and the public may weigh the risks posed by the medical profession against the benefits they attributes to medicine; while heart surgery is risky the risk of not having heart surgery can be greater. The perception of even a small risk associated with osteopathy may put patients off, given that osteopathy's benefits are unproven. Osteopaths therefore need regulation to reassure patients and the public that osteopathy is safe.

Osteopaths need the legitimacy that regulation brings and must avoid becoming misaligned with their wider institutional and regulatory contexts (Black, 2005). The wider context of health care changed with the modernisation of the NHS and the introduction of 'clinical governance'(Scally and Donaldson, 1998), with health care policy moving towards a more 'scientific-bureaucratic' model (Harrison et al., 2002, Waring et al., 2010), and consequent changes to the regulation and 'revalidation' of health care professions in the UK (Department-of-Health, 2007, Department-of-Health, 2011). Having regulatory systems in place provides professions with a legitimacy they need at the wider societal level.

Regulation is often developed in response to high profile cases of professional malpractice (Hood et al., 2004, Hood and Lodge, 2005, McGivern and Fischer, 2010, 2012). Politicians may need to be seen to 'do something' following rare cases of 'one bad apple'. However, the resulting regulation may be less appropriate for the wider professional population of 'good apples'. At the same time, professionals can become detached from changing social norms and public expectations. Regulation is a conduit between professions and their wider context and Regulators play an important role translating regulatory policies into practice. Regulators need to balance, on one hand, ensuring professionals respond and adapt to policy makers', societal, public and patients' expectations of clinical practices, professionalism and regulation, with, on the other hand, maintaining professional norms and practices essential to good professional practice.

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