CODE OF PRACTICE – OSTEOPATHY

PRODUCED BY THE COUNCIL FOR THE PROFESSIONS COMPLEMENTARY TO MEDICINE

March 2013

1. The osteopath must have well-developed interpersonal communication skills and the ability to adapt communication strategies to suit the specific needs of the patient.

2. Respect for the patient as an individual should be demonstrated at all times, ensuring that professional responsibilities and standards of practice are not influenced by age, gender, religion, sexual preference, nationality, party politics and social or economic status. The same quality of service should be provided to all patients.

3. Gaining consent is fundamental prior to the examination and treatment of a patient. For consent to be valid, it must be given voluntarily. The patient needs to understand the nature, purpose and risks of the examination and treatment proposed and must be free to either accept or refuse the proposed examination or treatment. Good communication is especially important when the examination or treatment of intimate areas is proposed.

4. The osteopath must offer support and appropriate after care advice following the consultation.

5. The osteopath should be familiar with the concepts and principles of osteopathy and be able to apply them clinically.

6. Formal training should ensure that the necessary knowledge and skills are acquired by the practising osteopath. The osteopath must show competence and ability to identify where a presenting problem may mask underlying pathologies. As a primary healthcare professional, the osteopath should refer to other health care professionals if deemed necessary.

7. Palpatory skills should be an integral part of the osteopath's clinical tools for diagnosis and treatment.

8. The osteopath must show competence in evaluating the clinical findings.

9. Research and reflection should be an integral part of the osteopath's continuous professional development and clinical decision making process.

10. It is highly recommended that an osteopath carries out continual professional development.

11. Based on a detailed clinical case history and analysis, a working diagnosis and treatment plan should be formulated by the osteopath. The working diagnosis should also be based on clinical investigations and special tests performed.

12. Accurate records are to be kept for all patients. Any reports or findings relevant to the patient should be filed appropriately together with the patient notes. All records are strictly confidential and information which the patient gives to the osteopath is to be treated in the strictest confidence. No information may be disclosed without the consent of the patient, except when compelled by law.

13. The dignity and modesty of the patient are paramount at all times. The patient should be offered a chaperone when examining or treating an intimate area. It is advisable to let the patient know before the treatment session, that they may need to undress for examination purposes. Parts of the body that do not need to be exposed for examination or treatment should be covered; alternatively, the patient can remain partially dressed.

14. In the event that the patient needs to remove their underwear for examination or treatment, they should be encouraged to put it back on as soon as the particular examination or treatment procedure has been concluded. Obtaining written consent is advisable in these scenarios. **Examples** of clinical scenarios include: coccygeal adjustment and any other rectal technique or examination, vaginal technique or examination, palpation of the symphysis pubis, sacrum, pirformis muscle, palpation of the groin, perineum, breast. This list is not exhaustive and some patients may regard other areas of the body as 'intimate' and this should be respected.

15. The osteopath should be able to value and understand the importance of the input from other healthcare professionals.

16. The osteopath is not obliged to accept every patient. In certain situations, the osteopath may also refuse to continue treating a patient. Effort should be made to refer them to another osteopath. Some examples include:
    - aggressive behaviour of the patient towards the practitioner
    - no confidence in the care the osteopath is providing
    - patient becomes inappropriately dependent on the osteopath.

17. Potential students of osteopathy may be allowed to observe an osteopath at work, provided that the patient consents to it and their presence is not hindering the effectiveness of treatment in any way. The presence and identity of an observer is to be recorded on the patient's notes.

18. When expressing opinion or when commenting on other healthcare professionals, the osteopath must be factual and accurate.

19. The osteopath should be in a good state of health which does not compromise the level of care given to patients.

20. Knowledge and awareness of the relative and absolute contra-indications of particular techniques to different clinical scenarios is of paramount importance at all times. (Appendix 1)

If at any time, guidelines, codes or policies are considered to impede the safe and effective performance of osteopath's duties, proposals for change should be initiated through The Council for the Professions Complementary to Medicine.
This code should be read in conjunction with Part V, Articles 25 to 28 of the Health Care Professions Act, 2003 (Cap. 464).

References

The Scope of Osteopathic Practice in Europe (draft version) retrieved Jan 26th 2012 from http://www.efo.eu/Osteop-Practice-Europe.pdf

General Osteopathic Council (2012) 'Osteopathic Practice Standards'

It is highly recommended that every Osteopath carries out Continuing Professional Development.

Appendix 1

WHO Draft: Guidelines on safety and practice of osteopathy and osteopathic medicine

Contraindications

Patient refusal or absence of informed consent (verbal and/or written) is an absolute contraindication to the application of any technique or treatment.

1 Direct techniques:

1.1 Absolute contraindications to any direct technique (systemic conditions):

- uncontrolled or suspected bleeding disorders
- prolonged bleeding times
- treatment with anticoagulant pharmacotherapy without recent evaluation of therapeutic level
- clotting abnormalities
- congenital or acquired connective tissue diseases that result in compromised tissue integrity
- compromised bone, tendon, ligament or joint stability as might occur in metabolic disorders, metastatic disease, rheumatoid diseases

1.2 Relative contraindications to direct technique

- osteoporosis
- osteopenia
- paediatric patients who have not reached puberty
- elderly patients

1.3 Absolute contraindications to direct techniques specifically applied at the local site

- aortic aneurysm
- acute hydrocephalus
- hydrocephalus without diagnostic workup
- acute intracerebral bleed
- acute cerebral ischemia, including transient
- suspected arterial-venous malformation
- cerebral aneurysm
- acute cholecystitis with suspected leakage or rupture
- acute appendicitis with suspected leakage or rupture
- acute or subacute closed head injury
- acute disc herniation with progressive neurological signs
- evidence of vascular compromise:
    - o carotid bruit
    - o aortic bruit
    - o ocular bruit

- suspected vertebral artery compromise:
    - o syncope
    - o vertigo
    - o known congenital malformation

- acute cauda equina syndrome
- ocular lens implant (early post-operative period)
- uncontrolled glaucoma
- neoplasm
- suspected or risk of bone compromise such as osteomyelitis, bony tuberculosis, etc.

1.4 Absolute contraindications to direct techniques specifically involving thrust or impulse applied at the local site:

- specific technique at the site of internal fixation
- compromised bone or joint stability as might occur focally in neoplasm, metastatic disease, suppurative arthritis, septic arthritis, rheumatoid diseases, osteomyelitis, bony tuberculosis, etc.
- acute fractures (although physicians may appropriately use mobilization/manipulation to reduce a dislocated joint or comminuted or displaced fracture, this may or may not be performed under anesthesia)
- bony or intramuscular hematoma

1.5 Relative contraindications to direct techniques using thrust or impulse at the local site:

- vertebral disc herniation without progressive neurological signs
- strained ligaments
- acute acceleration-deceleration injury of the neck

2 Indirect, fluid, balancing, and reflex based techniques:

- Relative contraindications to indirect techniques usually concern the acuity of the problem.

2.1 Absolute contraindications to indirect, fluid, balancing, or reflex based techniques applied at the local site

- acute hydrocephalus without diagnostic workup
- acute cerebral bleed
- acute intracerebral vascular accident (hypoxic or ischemic)
- suspected arterial-venous malformation
- cerebral aneurysm
- suspected acute peritonitis
- acute appendicitis or other visceral disease with suspected leakage or rupture
- recent closed head injury with suspected internal derangement

2.2 Relative contraindications to any indirect, fluid, balancing, or reflex based technique applied at the local site

- metastastatic disease
- neoplasm
- acute closed head injury