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Editorial

Core competencies in osteopathy: Italian register of osteopaths proposal



Background

The concept of competence is central to the professional system to ensure practitioners possess an adequate profile that enables them to effectively perform their role. In this editorial, we build on the concepts of competence and clinical reasoning to propose a core competence framework for osteopathy in Italy, which can inform current legislative development and future professional training and education. Apart from the specific context of Italy, this framework may also play a critical role in the development of professional education and regulation worldwide. The aim of this editorial is to initiate critical discussion on the topic of professional competence amongst educators, regulators and practitioners in the field of osteopathy.

In the literature, there are different definitions of competence, including the commonly cited one proposed by Epstein and colleagues [1] - “*professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served*”. In the health professions, the terms competence and competencies are used interchangeably, on occasion to describe the same concept, at other times to describe different aspects of professional practice. Competence is based on clinical skills, scientific knowledge, and moral development. It includes cognitive, integrative, relationships and affective/moral functions in the process of patient care. In contrast, competency is related to the use of a structured set of knowledge, skills, and attitudes in a specific professional context, or in professional training. Therefore, professional competence is more than a demonstration of isolated competencies; it is the ability to manage ambiguous problems, tolerate uncertainty, and make decisions with limited information [2]. In the health professions, professional knowledge is centred on the application of core knowledge through clinical reasoning, incorporating scientific, clinical, and humanistic judgment, and metacognitive strategies which enable practitioners to identify and address gaps in their knowledge using external resources, such as Evidence Based Practice (EBP) [3]. There is consistency among different healthcare disciplines on the importance of EBP used by clinicians. To this end, recent studies consider it as a competence [4–6] defined as “*the ability to ask clinically relevant questions for the purposes of acquiring, appraising, applying, and assessing multiple sources of knowledge within the care context for a particular patient, group, or community*” [7,8]. Skills relate to profession-specific technical procedures such as a clinical examination or specific therapeutic intervention, and attitudes based on emotional intelligence, tolerance of ambiguity and anxiety, and metacognitive capabilities designed to monitor one's own thinking.

These different dimensions of professional competence should inform the process of clinical reasoning and patient care [9].

Clinical reasoning, including its underpinning cognitive, meta-cognitive and perceptual processes, build on the foundation of EBP competence. Traditional models of clinical reasoning in the health professions build on the best evidence available and they refer to a cognitive practitioner-centred process whereby practitioners gather information about their patients, evaluate that information and develop treatment and management plans taking into account relevant research literature and clinical guidelines [10]. Clinical reasoning is a critical capability in autonomous professional practice, and it draws heavily on professional knowledge and decision-making strategies that are specific to each health profession [11]. Consequently, pre-registration and post-qualifying education and training of healthcare professionals should be based on the core competence profile required for that specific professional context [1,12]. Regarding osteopathy, and considering the specific case of Italy, recent developments in legislation designed to regulate osteopathy as a health profession require the development of a document that clearly defines the core competencies in osteopathy. This document would then become central to osteopaths' professional profile and training in Italy.

Osteopathy

Osteopathy offers a patient-centred system of evaluation, treatment and management that can be applied across a wide range of medical conditions. It is traditionally based on the principle that the structure and functions of the body are closely integrated, and that a person's well-being requires the neurological, musculoskeletal, circulatory and visceral structures to work in harmony [13]. Authors in the field of osteopathy, argue that the application of osteopathic principles, the structural diagnosis and the use of osteopathic manipulative treatment (OMT) in patient care, is what differentiates osteopathy from other health professions. OMT aims to restore and maintain a person's body to its overall natural state of well-being through homeostasis [14]. This process is underpinned by three key osteopathic principles, i.e., body unity, structure-function interrelationship and self-regulation [15]. It has been argued that these principles incorporate current medical and scientific knowledge, with primary focus on osteopathic clinical research when applying the principles to patient care [16].

In some countries, the osteopathic practitioner's approach to diagnosis and treatment is underpinned by five models of structure-function interrelationship, i.e., biomechanical, neurological, metabolic, respiratory-circulatory and behavioural models [17,18]. These models can be used in combination to provide a

framework, which enables practitioners to critically evaluate the significance of somatic dysfunction or other clinical findings obtained through both objective and subjective clinical examinations [19]. Authors in the field of osteopathy, have proposed that the combination chosen is adapted to the patient's differential diagnosis, co-morbidities, other therapeutic approaches and response to treatment [20].

Arguably, clinical reasoning in osteopathy may be underpinned by these models of structure-function interrelationship and within a continuum between practice and evidence from technical rationality (a practitioner-centred, physical, biomedical and biomechanical based approach) to professional artistry (a patient-centred, behavioural based approach) [21,22]. We propose that the goal of clinical reasoning in osteopathy is to identify, prioritise and deliver osteopathic care through a critical application of these five osteopathic models. This may be achieved through a multi-stage reasoning process that usually begins with a biomedical approach to identify red flags for serious underlying pathology, and culminates in specific osteopathic diagnostic approaches that include the judicious use of palpation [23]. Diagnostic palpation is an important part of an osteopath's clinical competence profile, and together with the critical evaluation of osteopathic principles, plays a significant role in osteopathic clinical decision making process [24]. It has been argued that the specific structure-function interrelationship models, grounded in osteopathic principles, differentiates osteopathic clinical reasoning from other health professions and enable osteopathy to be regarded as a health profession and not a technique [22,25].

Osteopathic care is centred on important health needs of the population: prevention, promotion, treatment and support. Although these areas are in common with other health professions, mostly in the field of physical medicine and rehabilitation, strong multidisciplinary collaborations between osteopaths and other health care practitioners are required to overcome preciously guarded professional boundaries if the patients' best interests are to be served [26,27]. Higgs and Jones [28] have proposed that clinical reasoning should be interdisciplinary in order to 'transcend the boundaries of professional groups, with their diverse backgrounds, and includes patients as part of multidisciplinary teams'. On this point, we propose that osteopaths need to be play a greater role in multidisciplinary decision making and represents added value

for health care [29].

The Italian Register of Osteopaths (ROI), the most representative osteopathic professional association in Italy, decided to produce an Italian Core Competence Framework in Osteopathy, based on the Italian health care system.

The ROI Proposal of Italian Core Competence Framework in Osteopathy

'Experts working group'

A Core Competence Framework is a conceptual model to develop core competences based on local, political, social, and economic circumstances [30] and may not simply be translated from the existing versions [31]. The ROI, has been playing an active role in the recognition of osteopathy as a health profession in Italy, and has created an 'experts' working group to develop a ROI Proposal of Italian Core Competence Framework in Osteopathy, to support the ongoing legislative process. Subsequently, this work will be submitted to the national and international scientific osteopathic communities for their approval through an interactive consensus process. The 'experts' working group is composed of 8 osteopaths, with at least 10,000 hours of professional practice in the fields of medical education, scientific research, clinical practice and training and two medical education experts from the Italian Society of Medical Education (SIPeM) [32,33]. The Guilbert framework was used to develop the Italian osteopathic core competence framework [34]. It provides a top-down model and defines "competence domains" as "functions" and "competencies" as "activities" allowing one to define the role of profession, within the healthcare system, based on the health needs of the population.

The meaning of functions and activities

The Guilbert framework considers that health professionals give different meanings to the words "knowledge", "skills" and "attitudes" when discussing educational issues and this ambiguity often leads to incomprehension. Educational objectives need active non-ambiguous verbs to achieve better communication between teachers and learners and to assess that complexity. For these reasons, Guilbert defines functions and activities as professional

Table 1

Function 1: Health promotion and prevention.

Function 1. Health Promotion and Prevention	
The osteopath must be able to:	
1.1	Recognize, within an inter-professional collaborative team, the biopsychosocial context in order to identify risk factors for health.
1.1.1	Recognize the centrality of the person in the healthcare system and in health promotion, emphasizing the person's self-reflection on his/her health.
1.1.2	Establish a symmetrical relationship between osteopath and community in order to raise awareness of healthy lifestyles.
1.1.3	Encourage the community to express its ideas about possible health promotion practices by involving it in decision making during the development of a long-term self-promoting health plan.
1.1.4	Identify the educational needs of the community on prevention issues, within an inter-professional collaborative team.
1.1.5	Evaluate the community's potential adhesion to adaptive health practice (AHP).
1.1.6	Formulate health educational strategies and preventive interventions within an inter-professional collaborative team.
1.1.7	Inform the community about the value of managing adaptive loads according to osteopathic principles and models in order to preserve health.
1.2	Educate the community to develop healthy behaviors.
1.2.1	Develop the community's critical thinking about superstitious health beliefs.
1.2.2	Promote, through resilient behaviors, biomechanical, neurological, respiratory-circulatory, metabolic, and behavioral self-regulation.
1.3	Promote community empowerment.
1.4	Promote health through an osteopathic manipulative treatment (OMT) focused on adaptation.
1.4.1	Prevent the alteration of adaptive capability of the person related to disease, within an inter-professional collaborative team.
1.4.2	Explain the biological, psychological and social aspects related to pain from a biopsychosocial point of view.
1.5	Educate the community to identify variations of its adaptive capability.
1.5.1	Educate the community to identify somatic dysfunction related signs and symptoms that could affect its health.
1.5.2	Educate the community to identify ergonomic lifestyle and behavior that could affect its health.
1.6	Motivate the community to practice exercise and adopt a healthy eating lifestyle, within an inter-professional collaborative team.
1.7	Evaluate the adherence of the health promotion plan to the goals of the community.
1.8	Participate in inter-professional screening and prevention campaigns.

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