



Original article

Clinical decision-making and therapeutic approaches in osteopathy – A qualitative grounded theory study



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ARTICLE INFO

Article history:

Received 18 April 2013

Received in revised form

5 July 2013

Accepted 12 July 2013

Keywords:

Clinical reasoning

Decision-making

Osteopathy

Grounded theory

ABSTRACT

There is limited understanding of how osteopaths make decisions in relation to clinical practice. The aim of this research was to construct an explanatory theory of the clinical decision-making and therapeutic approaches of experienced osteopaths in the UK.

Twelve UK registered osteopaths participated in this constructivist grounded theory qualitative study. Purposive and theoretical sampling was used to select participants. Data was collected using semi-structured interviews which were audio-recorded and transcribed. As the study approached theoretical sufficiency, participants were observed and video-recorded during a patient appointment, which was followed by a video-prompted interview. Constant comparative analysis was used to analyse and code data.

Data analysis resulted in the construction of three qualitatively different therapeutic approaches which characterised participants and their clinical practice, termed; Treater, Communicator and Educator. Participants' therapeutic approach influenced their approach to clinical decision-making, the level of patient involvement, their interaction with patients, and therapeutic goals. Participants' overall conception of practice lay on a continuum ranging from technical rationality to professional artistry, and contributed to their therapeutic approach. A range of factors were identified which influenced participants' conception of practice.

The findings indicate that there is variation in osteopaths' therapeutic approaches to practice and clinical decision-making, which are influenced by their overall conception of practice. This study provides the first explanatory theory of the clinical decision-making and therapeutic approaches of osteopaths.

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1. Introduction

Currently, the number of osteopaths in the UK exceeds 4500 (GOsC, 2012b) and practitioners are increasingly being considered as significant providers of manual therapy (NICE, 2009). Osteopaths in the UK are autonomous practitioners who diagnose and manage patients with a range of musculoskeletal conditions (Fawkes et al., 2010). Practitioners employ an array of therapeutic interventions, with 'hands-on' manipulative techniques (e.g. spinal manipulation) preferred by practitioners in the UK (Fawkes et al., 2010) and internationally (Johnson and Kurtz, 2003; Orrock, 2009).

Osteopathic practise is considered to be patient-centred (WHO, 2010; GOsC, 2012b) and underpinned by a core set of principles,

concepts and theories, many of which focus on the anatomical and physiological capabilities of the human body (Seffinger et al., 2003; Paulus, 2013). Currently osteopaths tend to be defined by their application of techniques, such as treatment applied to the: neuromusculoskeletal system often termed 'structural osteopathy' (Hartman, 1996); internal organs, termed 'visceral osteopathy' (Hebgen, 2010) and applied to the skull, termed 'cranial osteopathy' (Liem et al., 2004). Although these characterisations provide some useful description of the therapeutic techniques osteopaths employ, they offer a superficial understanding of practitioners' clinical practice and decision-making.

Over the last forty years researchers have been attempting to understand the nature and processes of clinical practice and decision-making. For example, in the physiotherapy profession there is a growing body of research on a range of aspects of practice such as the processes of clinical decision-making (Edwards et al., 2004; Cruz et al., 2012) and the nature and development of expertise (Jensen et al., 2000; Petty et al., 2011a,b). This research

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demonstrates that well-developed clinical decision-making skills are fundamental to expertise (Jensen et al., 2008). There is currently little-to-no research of osteopaths' clinical decisions-making and their approaches to practice (Thomson et al., 2011). A research-based knowledge of these areas of osteopathy would be valuable to educators and practitioners and ultimately help enhance patient care. The aim of this study was to develop an explanatory theory of the clinical decision-making and therapeutic approaches of experienced osteopaths in the UK.

2. Methods

2.1. Study design

The study used constructivist grounded theory (Charmaz, 2006). By exploring the different meanings and experiences of clinical practice and decision-making raised by participants, the main researcher (OT) co-created the data and ensuing analysis through an interactive process, and developed an "interpretive portrayal" (Charmaz, 2006, p. 10) of participants' views, perceptions and experiences.

2.2. Participants

Twelve UK registered osteopaths took part in this study. Recruitment adverts placed in osteopathic educational institutions (OEs) and the osteopathic press nationally, invited practitioners to contact OT should they wish to take part in the study. Upon initial contact, practitioners were provided with information and given the opportunity to ask any questions regarding the study. Having then expressed a wish to participate, details of practitioners' professional background (e.g. teaching/clinical experience, education, interests/specialities) were obtained and a list of potential participants was compiled. From this list, purposive sampling initially selected practitioners with a minimum of five years clinical experience, and currently held positions as clinical educators at an OEI. Clinical educators were expected to effectively communicate and verbalise their decision-making processes (Ajjawi and Higgs, 2008), enabling 'thick' data to be generated and enhance the credibility of the research findings (Lincoln and Guba, 1985). Subsequent theoretical sampling (Charmaz, 2006), informed by data analysis, led to specific participants being re-interviewed as well as additional participants being sampled who were not involved with osteopathic education. Table 1 provides participants' biographical information.

Each practitioner gave informed consent before participating. All patients gave informed consent before commencing each observation session.

2.3. Data collection and analysis

In line with the iterative nature of grounded theory, data collection and analysis occurred concurrently (Charmaz, 2006). A total of seventeen semi-structured interviews were transcribed verbatim, read/re-read and analysed throughout the course of the study. During the data collection process, the interview guide became progressively focused so that concepts constructed from data analysis could be pursued and ideas explored (Table 2). Data was initially collected from interviews with nine participants (P1–9). Three participants (P6–8) were theoretically sampled and re-interviewed as they each exhibited strong characteristics of the therapeutic approaches which were developing from analysis. As the study approached theoretical sufficiency (Charmaz, 2006), a further three participants (P10–12) were observed and video-recorded during a patient appointment, which was followed by a video-prompted reflective interview (Haw and Hadfield, 2011).

Table 1
Biographical information of study participants.

Participant	Gender	Years since graduating	Qualifications	Teaching position held
1	M	13	BSc (Hons) Ost	Clinic tutor and lecturer
2	M	14	BSc (Hons) Ost Med, Dip Ost	Clinic tutor and lecturer
3	M	6	BSc (Hons) Ost Med, Dip Ost, MSc	Clinic tutor and lecturer
4	M	16	Dip Ost	Clinic tutor and lecturer
5	F	13	BSc (Hons) Ost Med, Dip Ost	Clinic tutor
6	M	25	BSc (Hons) Ost Med, Dip Ost, MSc	Clinic tutor and lecturer
7	M	9	BSc (Hons) Ost, Med, Dip Ost, Dip Naturopathy, MSc	Lecturer
8	M	22	BSc (Biochem) \Dip Ost	Clinic tutor
9	F	22	BSc (Hons) Ost Med, Dip Ost, Dip Naturopathy	Clinic tutor and lecturer
10	M	6	BSc (Hons) Psych, BSc (Hons) Ost Med, Dip Ost, MSc	None
11	M	14	BA, BSc (Hons) Ost, Dip Ost,	Clinic tutor and lecturer
12	M	19	BSc Ost	None

OEI: Osteopathic Educational Institution; BSc: Bachelor of Science; DO: Diploma in osteopathy; MSc: Master of Science.

Non-participant observations of 'real-life' patient appointments enabled the researcher to compare the similarities and differences between the 'espoused theory' generated during interviews with 'theory-in-action' (Argyris and Schön, 1974). An observation guide (Table 3) enabled OT to make theoretical connections between what previous participants had said during interviews with what was observed during clinical sessions, providing further analytical insights. The video-recording deepened participants reflection during interviews, helping to ensure discussion were closely tied to participants' actions and decisions, which took place during the clinical appointment (Haw and Hadfield, 2011). Towards the end of the study two participants (P1,10) were theoretically sampled and re-interviewed to explore and test out the proposed core category of 'conception of practice' (Fish and Coles, 1998) and further develop the theory. The major analytical processes used were:

2.3.1. Coding

The active construction of codes during analysis formed a link between data collection and development of the theory and helped explain and understand conceptual reoccurrences and patterns in the data (Birks and Mills, 2011). During the early stages of analysis initial line-by-line coding (Charmaz, 2006) was employed to define actions or events of a given situation. Focused coding, was then used to assess which codes appeared to be the most significant (Charmaz, 2006). This led to the development of new focused codes which were used to analyse larger segments of data. This process elevated the level of conceptual analysis so that broader categories could be developed.

2.3.2. Constant comparative analysis

This involved comparing data with data, data with category, category with category (Charmaz, 2006). Constant comparison was used throughout data analysis, from initial coding to advanced levels of analysis when writing up the findings.

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