

**An exploration of the influences that shape the opinions
and practices of osteopaths in relation to osteopathy in the
cranial field**

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ABSTRACT

Despite its popularity osteopathy in the cranial field (OCF) is perhaps the most controversial modality within the osteopathic profession; yet little is known about how or why such differing opinions about OCF develop. This study explored the influences that shaped the opinions and practices of osteopaths in relation to OCF.

The study employed a qualitative approach with an interpretive descriptive method. Convenience and purposive sampling strategies were used to recruit thirteen individuals who participated in data collection for the study. Data collection involved three semi-structured focus groups, whose members held either strong opinions against OCF, neither strong opinions for nor against OCF or strong opinions for OCF. Two individual interviews were also held with key informants; one key informant with strong opinions against OCF and one with strong opinions for OCF. After interpretive thematic analysis of the focus group and individual interview transcripts, themes were identified.

The key shaping influences of the participants' opinions of OCF and their decision whether or not to practice OCF were presented within three thematic groups: identified as 'me', 'it', and 'they'. 'Me' included those influences that originated with the intrinsic needs or beliefs of the participants, 'it' referred to those influences that developed because of the participants' perceptions of the OCF modality, and 'they' incorporated the influences shaped by 'others' and at times their actions. The discussion for this study was based on the largely absent theme of 'us'. Although the participants from the three focus groups and two individual interviews had very different opinions about OCF, many of them used the same philosophy to support their opinions. In effect the participants were using the same philosophy to support very different viewpoints. This suggests

that there is a lack of consensus about what osteopathy is, and this affects osteopaths' opinions about OCF. The relationship between the past and present also had a significant impact on the participants' opinions. The past had significant implications when it came to research and evidence based practice, spirituality and dogma.

Keywords: Osteopathy in the cranial field; OCF; opinions; debate; controversy; influences.

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Figure 1. The structure/function, min/max treatment axis

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TABLE OF ABBREVIATIONS

| | |
|-----|---------------------------------|
| OCF | Osteopathy in the cranial field |
| CSF | Cerebrospinal fluid |
| PRM | Primary respiratory mechanism |
| CRI | Cranial rhythmic impulse |
| SOT | Sacro occipital technique |
| CST | Craniosacral therapy |
| FGA | Focus Group A |
| FGN | Focus Group N |
| FGF | Focus Group F |
| KIA | Key Interview A |
| KIF | Key Interview F |
| EBP | Evidence based practice |

CHAPTER ONE – INTRODUCTION

Introduction

There is an ongoing joke within the osteopathic community that goes something like this:

Question: What do you call a group of osteopaths?

Answer: A disagreement.

As with most controversial issues there are those who sit on the fence and those who invariably sit either side of the fence; the debate surrounding osteopathy in the cranial field (OCF) is one of these issues. Despite being widely used by many osteopaths in New Zealand, the practice of OCF under the umbrella of 'osteopathy' is strongly opposed by others. With the osteopathic community's history of division and disagreement the controversy that surrounds OCF is a problem for the future of osteopathy as a unified profession. This is of particular concern because complementary and alternative therapies in New Zealand are increasingly scrutinised by regulatory bodies, media and general public; osteopaths need to present a united front.

The research described in this thesis is an interpretive descriptive study that explored the influences that shaped the opinions and practices of thirteen osteopaths in relation to OCF.

In this chapter a brief background to the study is provided including my personal interest in the topic and how the concept for this research eventuated. The rationale behind the project is discussed along with the aims and objectives.

Finally a summary concludes this chapter with a basic outline of how this thesis will be presented.

Background

Osteopathy has had a somewhat brief and marginal history in New Zealand over the last forty years. It has only been in the last seven years that osteopathy has been formally recognised within the New Zealand healthcare system with the passing of the Health Practitioners Competence Assurance Act (2003) (Baer, 2009). Despite this, osteopathy is a rapidly growing system of healthcare in New Zealand (Baer, 2009).

Osteopathy is a comprehensive, scientifically based system of manual healthcare that works primarily with the neuromuskuloskeletal system to encourage health (Ward, 2003). The original osteopathic concept of health was created by Andrew Taylor Still over 100 years ago and has evolved throughout its history. This philosophy of health has been condensed into a set of four generally accepted principles. These are:

1. The body is a unit.
2. The body is inherently self-regulating and self-healing.
3. Structure and function are reciprocally interrelated.
4. Treatment is based on these principles.

These four principles provide the basic theory upon which the majority of osteopathic diagnostic and treatment models have been based. Despite these models sharing similar theoretical grounding there are major differences in the way treatment and diagnostic models are applied. There are many reasons why practitioners would choose to use different treatment approaches. These reasons include, not only what is best for the patient but also what the practitioner has learnt during their education, the practitioner's confidence in

these approaches and the practitioner's own personal preference (Chaitow, 2005; Johnson & Kurtz, 2003).

There is ongoing debate over the efficacy and place of many of the treatment modalities within the osteopathic profession; one of the most debated modalities is osteopathy in the cranial field (Chaitow, 2005; Moran, 2005). Although widely used and highly popular amongst patients, the use of OCF seems to have divided the osteopathic community more than any other issue (Maddick, 2007; Moran, 2005). The implication of this is that ultimately the profession is divided about what should and should not be part of osteopathic practice, perhaps challenging the meaning of osteopathy.

Why study the influences that shape osteopaths' opinions about osteopathy in the cranial field?

My desire to study the topic of this research thesis originated largely from personal experience. The debate surrounding OCF within the osteopathic profession is highly visible and from my daily interactions with osteopaths it became apparent that this was a significant issue for the osteopaths.

Before starting my osteopathic education my perception of what an osteopathic treatment consisted of, was somewhat different to what it is today. My experience as a patient was that all osteopaths used OCF treatment and that OCF and osteopathy were somewhat synonymous. As I found out this could not be further from the truth.

The OCF module consisted of only one semester for which there was a two hour lecture/practical class per week. In comparison, the entire osteopathy programme consisted of approximately twenty hours of contact time, per week, for ten semesters. This demonstrates that OCF was in fact a small component of the osteopathic programme I studied in. Furthermore, once starting the

postgraduate clinical component of the Master of Osteopathy degree it was clearly evident that a significant number of tutors and lecturers had a somewhat negative opinion of OCF. This made me start to ponder; is this how most osteopaths feel about OCF? And was my pre-study experience of OCF not a true representation of osteopathic practice as a whole? In reviewing research editorials and other professional literature it became obvious that OCF is a contentious topic within the osteopathic community. It was incredibly difficult, however, to ascertain whether these extremes of opinion about OCF were indicative of how the majority of osteopaths felt or whether this was a persistent, vocal minority.

Because experiences help shape our opinions I started to consider how the educational institute I was attending was affecting my opinions of OCF. Finding that there was a lack of research in this area led me to ask, “what does influence osteopaths’ opinions about OCF and why is there so much controversy and contention surrounding this particular modality? ”.

Rationale for the study

“Osteopathy in the cranial field seems to attract more widespread and vigorous critical attention than all other components of osteopathic practice combined” (Moran, 2005, p. 80). The debate over its use has become so intense that there have been suggestions that OCF be removed from academic curricula and not be practiced at all (Ferré & Barbin, 1991; Hartman, 2006). Such statements have serious implications for whether OCF should remain within the osteopathic scope of practice.

There is research beginning to emerge that demonstrates positive physiological effects from OCF treatment (Collard, 2009; Milnes & Moran, 2008). Anecdotally, clinical practice of OCF does seem successful, however research has yet to validate its efficacy (Ferguson, 2003). It has been suggested that future OCF

studies need to have greater clinical relevance and that there needs to be collaboration with experts in the OCF field to determine the effectiveness of OCF as a treatment (Leach, 2008; Moran, 2005).

The purpose of this study was therefore to begin to develop a greater understanding of the controversy surrounding OCF by seeking some insight into why osteopaths feel the way they do about OCF. The knowledge generated from this study may help direct further research into this field, and also assist in informing the debate, so that the issue can be addressed at a future date. This would appear rather pertinent for a healthcare profession deliberating over changes to their current scope of practice (The Osteopathic Council of New Zealand, 2010).

Aims and objectives of this study

The aim of this project was to begin to explore the influences that shape the opinions and practices of osteopaths in relation to OCF.

The objectives were to:

- Identify the influences that shape osteopaths' opinions of OCF.
- Identify why osteopaths choose to use or not to use OCF in their practice.

Thesis overview

This thesis has been written in five chapters. Chapter One has introduced the controversy that exists over the use of OCF, along with my personal interest in the topic and the rationale behind conducting this study. Chapter Two reviews the literature relating to osteopathy; in particular osteopathy in the cranial field

and the controversy surrounding its use. Chapter Three outlines the methodology and method used in this research, including how participants were selected, the data analysis using interpretive description, ethical considerations for the study and answering the question of rigour. In Chapter Four the themes that emerged from the study are presented using excerpts from the focus groups and interviews. Finally, Chapter Five discusses these findings in relation to osteopathic literature as well as literature from other healthcare professions. The implications for the profession, limitations of the study and recommendations for future research are also discussed, followed by the concluding thoughts for the project.

CHAPTER TWO – LITERATURE REVIEW

Introduction

Since its origins in the early nineteenth century osteopathy in the cranial field has been a catalyst for debate within the osteopathic profession. Despite its popularity with patients and some practitioners, OCF continues to cause division within the osteopathic community today.

This severance separates two very different beliefs about OCF; that there is significant anecdotal evidence supporting positive patient outcomes and contrastingly that there is a lack of scientific evidence supporting its use. Literature would suggest that this is the driving force behind the considerable differences in opinion about OCF. There is, however, a lack of research identifying why osteopaths have such disparate opinions about this modality. Research that begins to investigate the influences that shaped these opinions may provide greater understanding about this often, fierce debate surrounding OCF.

This literature review begins with a descriptive discussion, outlining the historical and philosophical background of osteopathy. The OCF modality is then discussed in more detail. Research into the OCF field is also presented to better inform the reader of the perceived issues surrounding OCF research and how this contributes to the controversy. Finally the literature outlining the debate about OCF within osteopathy will be discussed. There is currently no research that looks at the influences that shape osteopaths' opinions about OCF.

A review of literature was conducted via Internet and library database searches. The primary search engine used for these purposes was 'Google Scholar' at <http://www.google.com>. ScienceDirect, Elsevier and EbscoHost were the

primary databases used to identify literature using a list of key words combined with 'osteopathy in the cranial field' including; opinions, controversy, debate, influences and lack of evidence. All reference lists of literature retrieved in this manner were then reviewed for any further studies that may have provided insight into the study. Because of the nature of the study, which included looking at the progression of the osteopathic profession in relation to OCF, the date range of articles was not considered significant and was therefore not an exclusion criterion.

The history of osteopathy

Osteopathy's origins

Osteopathy was created at a time of great change for its founder, medical physician Andrew Taylor Still; the American civil war had come to an end and he had lost three of his children to meningitis. Through these experiences and many others, Still had become disillusioned by what mainstream medicine offered, believing that patient care and treatment was severely inadequate (Still, 1910; Ward 2003). Still chose to turn his back on traditional methods of treatment including surgery and pharmacology believing that the body contained all it needed for health and wellbeing (Still, 1910). It was in this context that Still developed his 'osteopathic philosophy'.

Still was powerfully driven by two almost paradoxical concepts; that of science, and that of spirituality. Still was very much the scientist, drilling his students about the importance of anatomy and physiology. To Still, osteopathy was in itself a science, strongly believing that investigation and questioning was thus an important part of osteopathy (Still, 1910). McPartland and Skinner (2005) discuss however, that despite Still's perception of osteopathy as a science, ultimately Still's osteopathy "extended beyond that of known science and rational explanation" (p. 21).

Still was also a very spiritual man. It is believed that Still was deeply influenced by his Methodist parents, the spiritualist and universalist movements and the philosophy of pragmatism (Ward, 2003). Still strongly believed that the human body was, as he coined, a “complicated perfection” (Still, 1910, p. 7). The role of the osteopath was therefore that of the “mechanic” (Still, 1910, p. 10) whose calling was to encourage the body’s own innate ability to self-heal (Still, 1908, 1910). Still also had a strong belief in the ‘triune’ characteristic of man, a concept of man being a unified whole of mind, body and spirit; as Still said “First, there is the material body; second, the spiritual being; third, a being of mind which is far superior to all vital motions and material forms, whose duty is to wisely manage this great engine of life.” (as cited in Lee, 2005, p. 37).

Still often talked of the “great architect” (Still, 1908, p. 330), and stated that it was God himself who was the “Father of osteopathy” (Still, 1908, p. 254). Still was therefore, an interesting, if not controversial character, a man who was passionate about his belief in God, osteopathy and the potential of man.

What is osteopathy?

There have been many attempts to devise one succinct definition of osteopathy but it is difficult to capture the true essence of osteopathy within one definition. Arguably it is the application of diagnosis and treatment according to osteopathic principles that differentiates osteopathic practice from other manual practices (Stone, 2002). These principles are the core of the osteopathic philosophy and although these have been condensed over the years they largely deliver a similar message to that put forward by Still over a hundred years ago. These are generally considered to be:

1. The body is a unit

The health of a person is a balance between body, mind and spirit. When any one of these domains are stressed or altered it will inevitably affect the rest of the system. Therefore, when diagnosing and treating patients the practitioner must acknowledge the integration of the anatomical,

physiological and psychosocial and treat the whole patient in their life context (Stone, 2002; Ward, 2003).

2. Self-regulation, self-healing and health maintenance

Under optimum conditions the body has the inherent ability to self regulate and self heal (Still, 1910; Ward, 2003). It is only when this homeostatic balance is upset that the symptoms of disease ensue. Osteopathic treatment aims to address this imbalance so that the body can return to health (Ward, 2003).

3. Structure and function are reciprocally interrelated

Osteopathic treatment can improve function by treating through the structural domain and conversely it can treat the structural domain by improving function. Structure therefore governs function and this relationship is reciprocally interrelated (Ward, 2003).

4. Rational treatment is based on applying these principles

The osteopathic practitioner understands that the neuromuskuloskeletal system, through its interdependent structure function relationships can positively and negatively affect the body's self-regulation and self- healing mechanisms (Parsons & Marcer, 2006; Ward, 2003).

Osteopathic scope of practice

Since the implementation of the Health Practitioners Competence Assurance Act (2003) the Osteopathic Council of New Zealand was created and appointed as the regulatory authority for the profession. Its role is to ensure public safety through effective regulation and monitoring of the profession including determining the scope of practice for osteopathy. The Osteopathic Council of New Zealand currently states the scope of practice as:

Registered osteopaths are primary healthcare practitioners who facilitate healing through osteopathic assessment, clinical differential diagnosis, and treatment of dysfunctions of the whole person. Osteopaths use various recognized techniques to work with the body's ability to heal itself, thereby promoting health and wellbeing. These osteopathic manipulative techniques are taught in the core curriculum of accredited courses in osteopathy. The ultimate responsibility for recognition of practice lies with the Osteopathic Council of New Zealand (The Osteopathic Council of New Zealand, n.d., Scopes of practice, para 5)

There are many models of diagnosis and treatment within osteopathy (Stone, 2002). Treatment approaches are therefore widely varied and may range from a very reductionist structural approach to a far more holistic approach. Techniques permitted under the osteopathic scope of practice are to date, poorly defined and this has been a contentious issue within the osteopathic community (C. Standen, personal communication, March 17, 2009; King, 2002; Stone, 2002).

Osteopathic treatment models

There are many treatment models within the osteopathic profession. Despite sharing the same philosophy the application of these different treatment models varies greatly.

The models sit on a continuum between a structural and functional approach. Within this approach continuum, each modality also sits on its own energy input continuum between maximal and minimal input. This is well demonstrated by the following diagram, illustrated and described by Parsons and Marcer (2006).

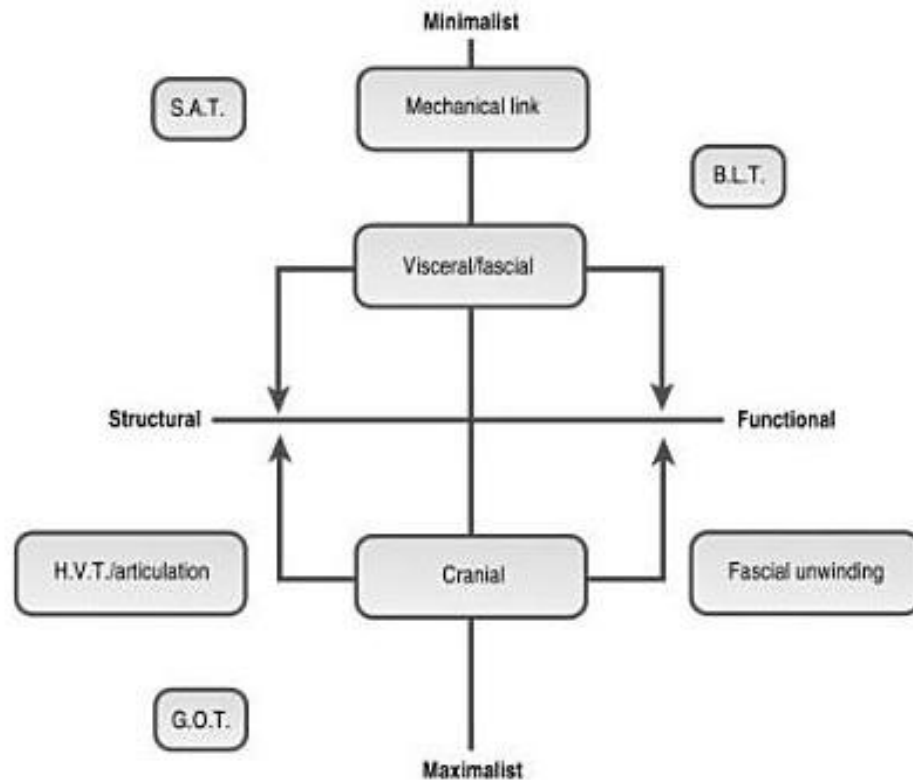


Figure 1. The structure/function, min/max treatment axis with treatment modality examples (Parsons & Marcer, 2006.)

A structural approach refers to taking the dysfunctional unit (for example a restricted vertebral segment) towards the restricted motion barrier to encourage increased mobility and function (Hartman, 2001; Parsons & Marcer, 2006). Functional techniques are diametrically opposite where the dysfunctional unit is taken away from the restricted motion barrier to a point of ease until free movement and function is restored (Hartman, 2001; Parsons & Marcer, 2006; Ward, 2003).

A maximalist approach refers to treatment that uses the whole body to affect all the parts (Parsons & Marcer, 2006). A minimalist approach alternatively treats the dysfunctional part of the body (what is often referred to as the osteopathic lesion) to influence the whole (Parsons & Marcer, 2006).

Although OCF can be seen to sit between the structural and functional approaches, some practitioners may use OCF in a very structural way, whilst others may employ a very functional approach. Osteopathy in the cranial field is

generally considered to be a maximalist approach as treatment tends to be of the whole body via the 'primary respiratory mechanism'¹ (PRM) but some practitioners may use OCF in a very minimal way i.e. working on a single cranial articulation. There are thus great differences in the way osteopathic practitioners practice OCF and it could be said that those who use OCF in a very structural or minimal way are not truly practicing OCF.

Applying treatment models

Different osteopathic practitioners may utilize predominantly structural or functional techniques, while some practitioners prefer to use a combination (Johnson & Kurtz, 2003). This may be based largely on what the practitioner has learnt during their education and clinical experience, their personal preference and their confidence in their own ability to use the techniques (Johnson & Kurtz, 2003). In many situations a certain treatment model or specific technique may be clearly indicated, however the practitioner must also determine what they believe will be the most effective approach for that particular patient, on that particular day (Ward, 2003).

Osteopathy in the cranial field

A brief history of osteopathy in the cranial field

The concept of osteopathy in the cranial field was first postulated in the 1930s by William Garner Sutherland, one of Still's earliest students (Chaitow, 2005). Sutherland, like Still had a great passion for anatomy, and in particular became fascinated by the intricate bevelling that could be seen on the articular surfaces of many of the cranial bones. From this observation, he theorised that the cranial

¹ 'The primary respiratory mechanism' is the term used to describe the concept of physiologic action involved in the OCF modality (Sutherland, 1990).

bones articulated in such a manner that they were like the gills of a fish. He believed that this structure function relationship allowed movement much like respiration, with both an inhalation and exhalation phase.

Sutherland also hypothesised, that the cerebrospinal fluid (CSF) circulated down and around the spinal chord in a rhythmically, pulsatile and spiral fashion (Sutherland, 1990). It was this rhythmic fluctuation of the CSF that was generally theorised to drive the inhalatory and exhalatory movement of the cranial bones. The movement of the cranial bones and the contribution of fascial tensions within the cranium and spinal column led to the subsequent motion of the sacrum. Sutherland defined this combined mechanism as the PRM (Sutherland, 1990).

'The primary respiratory mechanism'

The PRM is the concept of physiologic action involved in the OCF modality (Sutherland, 1990). Primary: refers to the action having first or primary importance, respiratory: that the motion involves an inhalation and an exhalation phase, and mechanism: as it consists of a system of parts working together as a machine (Sutherland, 1990).

The components of the PRM as described by Sutherland (1990) are:

- Inherent motility of the brain and spinal cord
- Fluctuating CSF
- Mobility of intracranial and spinal membranes (membranes, dura etc.)
- Mobility of the bones of the skull
- Involuntary motion of the sacrum between the ilia

Sutherland believed that this impulse was driven by an invisible force referred to as the 'breath of life'², something within the CSF that had potency and intelligence and drove the entire mechanism (Sutherland, 1990). This suggests that much like Still, Sutherland was also a very spiritual and philosophical man. Sutherland was not the only OCF practitioner to refer to the 'breath of life' and indeed many osteopaths today still subscribe to this theory.

Although OCF was developed around the concept of the PRM, not all osteopaths including those who practice OCF agree about the health benefits of working with the PRM itself. In fact the existence of the PRM is a highly contentious issue.

The cranial rhythmic impulse

Osteopathy in the cranial field can, therefore, be seen to be primarily concerned with two physiological phenomena; the involuntary motion between the bones of the skull and the sacrum, and a rhythmic impulse within the cranium and spinal column (Chaitow, 2005; Magoun, 1976; Sutherland, 1990). These two phenomena combined are palpable as the 'cranial rhythmic impulse' (CRI) (Chaitow, 2005). The mechanism behind the CRI phenomenon is, however, poorly understood and many theories have been proposed about how this mechanism functions to produce the CRI movement (Chaitow, 2005; Upledger & Vredevoogd, 1983). These have ranged from mechanical, physiological and anatomical explanations such as the contraction and dilatation of the cerebral ventricles, to less tangible, somewhat spiritual explanations such as the 'breath of life' (Chaitow, 2005).

The CRI is considered to have a biphasic cycle of motion. Literature suggests there are a wide variety of palpable CRI rates ranging from 0.6 per minute to

²The breath of life is said to be an external force that generates the CRI (Chaitow, 2005; McPartland & Skinner, 2005). Sutherland was very careful to distinguish that he was not talking about 'air' but the vitalising force of life, using the following quotation from the bible "And the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life and man became a living soul." Genesis 2:7, King James Version" (Sutherland, 1990, p. 16).

10-14 per minute (Chaitow, 2005; McPartland & Skinner, 2005; Nelson, Sergueef & Glonek, 2006; Ward, 2003). The rate is also said to change depending on the physical, physiological and psychological state of the patient (Chaitow, 2005; Ward, 2003).

There are, therefore, significant differences of opinion throughout OCF philosophy, perhaps the only agreement being:

- That movement between the cranial bones exists
- That treating the mechanism may create a positive treatment response

Therapies considered similar to osteopathy in the cranial field

It is important to discuss at this point that although this study was investigating the influences that shaped the opinions of osteopaths about OCF there are other comparable modalities that are practiced in a similar way to OCF. Two of the most notable modalities are sacro-occipital technique (SOT) and cranio-sacral therapy (CST). Although SOT was not mentioned by the participants in this study CST was discussed briefly and this is detailed in the presentation of findings.

Sacro occipital technique

Sacro occipital technique sometimes called 'chiropractic craniopathy' was developed by chiropractor and osteopath Major B. DeJarnette, an acquaintance of Sutherland's who was greatly influenced by Sutherland's work (The Sacro Occipital Research Society International, n.d). DeJarnette's SOT utilises muscle testing as a form of analysis, diagnosis and treatment of the cranial sacral respiratory system (Keating, 2003; Pedrick, 2005).

Craniosacral therapy

Craniosacral therapy is thought to have originated through the scientific work of osteopath John Upledger and his colleagues after investigating Sutherland's primary respiratory mechanism. The theories and principles underlying CST are similar to that of OCF and often the two terms OCF and CST are used interchangeably (Upledger & Vredevoogd, 1983). There seems to have been a disagreement between Upledger and the Sutherland Cranial Teaching Foundation and thus the two are considered different modalities. One of the major differences is that only osteopaths can practice OCF whilst CST, which is not a regulated therapy in New Zealand can be practiced by anyone. The two terms should not, therefore, be used interchangeably and for this reason OCF and CST are used as two distinct terms for this thesis.

Different models within osteopathy in the cranial field

Within OCF itself, there is a spectrum of treatment approaches (Parsons & Marcer, 2006). Once again these can be placed on a continuum, from a 'biomechanical' to a 'biodynamic' approach. At the 'biomechanical' end of the spectrum, a more structural approach is taken to correct dysfunction of the bones and membranes, and to enhance the flow of CSF (Chaitow, 2005; Leim, 2004; McPartland & Skinner, 2005). An example of this would be structural mobilisation of an individual restriction between two cranial bones. The difficulty with this type of structural OCF is whether this is simply a cranial technique as part of regular osteopathic practice or whether it is indeed OCF. This creates a certain degree of confusion because of the relative similarity between structural OCF and regular osteopathy (Collard, 2009).

At the 'biodynamic' end of the continuum, a more functional approach is taken, treating dysfunction at any level in the system rather than focusing on bony and membranous structures (Chaitow, 2005; McPartland & Skinner, 2005).

Another documented difference between the two models is the concept of the driving 'mechanism' behind the cranial phenomena (Chaitow, 2005). Within the biomechanical model, the term 'mechanism' is used as a non-distinct collective term whilst within the biodynamic model 'mechanism' is defined through specific elements such as the 'breath of life' and different rates of the CRI (Chaitow, 2005; McPartland & Skinner, 2005).

Osteopathy in the cranial field training

Education providers and osteopathy in the cranial field

Osteopathic undergraduate programmes are provided either by Universities/Institutes of Technology or by autonomous colleges whose degree programmes are validated by a University. Osteopathy in the cranial field is generally taught as a minor part of these osteopathic undergraduate programmes. Further postgraduate study is optional and can be undertaken through the Cranial Academy and the Sutherland Cranial Teaching Foundation. Anecdotal evidence from Unitec staff members with experience of teaching in a wide variety of institutions strongly suggests that some education providers have more OCF based curricula than others. There has traditionally been disagreement and debate between these different providers. A study that looked at the possibility of standardisation between osteopathic education providers quoted a participant saying that the concept of standardisation was "simply wishful thinking" (Hristov, 2005, p. 16). Hristov (2005) also discussed how there was a mentality of "our institution is better than" (p. 16) between the different schools, which demonstrates that division within the osteopathic profession is not confined to the practice of OCF. This air of superiority may also begin to explain some of the angst that is generated surrounding the debate about OCF, which could be fueled by interschool politics.

Osteopathic education and osteopathy in the cranial field

Only one research paper investigating the effect of education on osteopaths' practice of OCF could be sourced for this literature review. This study involved interviews of osteopaths with several years of professional experience to find out about their OCF training and how they had integrated their education into practice (Wojna, 2006). Wojna (2006) noted that only a small portion of the information the participants had gained through their OCF education was being used in practice, and that there was no standardization of treatment procedures once in practice. The participants appeared to be developing their own personal way of treating, which was strongly influenced by the biodynamic model of OCF (Wojna, 2006).

Another finding of the study was that nearly all of the participants showed little interest in the scientific debate surrounding OCF, including the lack of evidential support of its practice. Five out of six participants interviewed believed that "when it works, it doesn't matter how" (p. 93) suggesting that the theories behind OCF are unhelpful and not an important part of OCF for these practitioners (Wojna, 2006).

The popularity of osteopathy in the cranial field

The popularity of osteopathy in the cranial field in New Zealand is an important contextual aspect of the OCF debate. It is, however, difficult to comment on the absolute popularity of OCF as there is no research available that has identified this information. Despite this there are a number of studies that provide information on the popularity of OCF in New Zealand and abroad.

One study conducted by Johnson and Kurtz (2003) investigated what osteopathic manipulative treatment techniques were preferred by contemporary osteopathic physicians in the United States of America (USA). Johnson and Kurtz's (2003)

study was motivated by a reduction in the use of osteopathic manipulative techniques by osteopaths in the USA. The study found that of 979 participants 60.3 percent of osteopaths never used cranial techniques (Johnson & Kurtz, 2003). The other 39.7 percent used OCF seldom, sometimes, often or very often with only 7.1 percent reporting using OCF very often (Johnson & Kurtz, 2003). Johnson and Kurtz (2003) also found that the osteopathic education system that the participants had been exposed to greatly influenced the participants' choice of osteopathic manipulative treatment.

It must be noted that there is a difference between osteopaths in New Zealand and osteopaths in the USA. In the USA osteopaths are Doctors of Osteopathic Medicine and are registered medical doctors whilst in New Zealand osteopaths are registered as osteopaths but not medical doctors. This potentially limits the comparability between the two countries' osteopathic professions. Because of a lack of research in this area however, the results do provide commentary on the use of OCF globally.

Fitchew (2010) who investigated work related musculoskeletal disorders amongst osteopaths practicing in New Zealand found that out of fourteen commonly used osteopathic techniques, OCF was the fifth most popular technique. He found that from a sample size of 79, 18.9 percent of respondents listed OCF as their most preferred technique of all osteopathic techniques available to them. This suggests that nearly one fifth of osteopathic practitioners in New Zealand predominately use OCF in their practices, demonstrating that despite being controversial OCF is a popular modality amongst osteopathic practitioners in New Zealand.

Despite studies like this study conducted by Fitchew (2010) that briefly touch on the popularity of different techniques within osteopathy, there is little research available that looks at the popularity of modalities like OCF.

The reliability and effectiveness of osteopathy in the cranial field

In a critical appraisal of available research, Green, Martin, Bassett and Kazanjian (1999) found that OCF research methods were inadequate and research protocols failed to conclusively evaluate the effectiveness of OCF.

Interexaminer and Intraexaminer reliability studies

Interexaminer reliability studies investigate the ability of two different practitioners to palpate the same cranial rhythmic impulse (CRI) rate whilst intraexaminer reliability studies examine the ability of the same osteopath to palpate the same CRI rate at different times. Green et al. (1999) found that interexaminer reliability had thus far been low, which led to the conclusion that there was insufficient evidence to support the use of OCF (Green et al., 1999). In later studies interexaminer reliability has also shown to be poor (Moran & Gibbons, 2001; Sommerfield, Kaider & Klein, 2004). Research completed at Unitec supports these findings with a study into intraexaminer and interexaminer reliability of palpation of cranial motion restrictions (Hancock, 2005). The study's findings did not support the use of palpation of cranial bone restrictions as a diagnostic technique (Hancock, 2005). Intraexaminer reliability was found to be fair to good in one study (Moran & Gibbons, 2001).

There is a theory called the entrainment hypothesis, however, that may begin to explain the poor results of interexaminer reliability studies. McPartland and Mein (1997) proposed that the CRI rhythm is produced by the integration, or entrainment, of multiple biological oscillations of both patient and practitioner. The practitioner would therefore have a significant effect on the CRI rate of the patient, thus changing the patient's individual rate as the two rhythms synchronise. This would subsequently suggest that two different practitioners would perceive very different CRI rates in the same patient due to the effect they as practitioners are having on the patient's rate.

The effectiveness of individual techniques

Research into individual OCF treatment techniques such as the CV4 technique has yet to establish significant evidence to support the use of OCF (Cutler, Holland, Stupski, Gamber & Smith, 2005; Green et al., 1999; Milnes & Moran, 2008). The CV4 technique a commonly used OCF technique, thought to compress the fourth ventricle creating widespread therapeutic change (Collard, 2009; Milnes & Moran, 2008).

Despite this, there is some evidence that OCF does indeed produce some physiological change in patients (Cutler et al., 2005; Milnes, & Moran, 2008). A pilot study conducted by Milnes and Moran (2008) failed to support the theorised effects of the CV4 technique that are commonly described in literature, they did however determine that there might be 'responders' and 'non-responders' to OCF treatment. A recent study expanded on this hypothesis investigating the notion of responders and non-responders to the CV4 technique. The results of this study support claims that the CV4 technique has the potential to increase parasympathetic activity, as measured by heart rate variability, but only in some individuals (Collard, 2009). Parasympathetic response changes may be associated with an individual's baseline autonomic nervous system activity, a history of physical trauma and height (Collard, 2009). Collard (2009) discussed how this might begin to explain why previous studies have revealed limited effectiveness of OCF techniques.

Several studies have measured the patient-oriented outcomes of OCF techniques on specific conditions such as tension-type headache (Anderson & Seniscal, 2006; Hanten, Olsen, Imler, Knab & Magee, 1999). Although Anderson and Seniscal (2006) found it impossible to determine if there was a positive treatment outcome, Hanten et al. (1999) showed significant patient-oriented improvement from the OCF treatment. This suggests further research is warranted.

There have been a number of other studies looking at patient-centred outcomes of OCF treatment with varying results. Unfortunately there is poor substantiation

of many of the findings due to a lack of robustness of the methodology (Collard, 2009).

Controversy surrounding osteopathy in the cranial field

Since its beginnings OCF has been an area of “debate, hypothesis and a significant degree of confusion” (Chaitow, 2005, p. 1). On one side of the debate there is considerable anecdotal evidence that OCF is an effective treatment modality, whilst on the other side research has failed to prove the validity of the OCF model (Ferguson, 2003; Leach, 2008; Maddick, 2007). Much of the current literature suggests that research has been poorly designed and directed, focusing on testing theories that many osteopaths believe to be outdated (Ferguson, 2003; King, 2002; Maddick, 2007). It seems that even within the population of the profession who use OCF there is clear debate about the plausibility of the different theoretical models (Ferguson, 2003; Ferguson, McPartland, Upledger, Collins & Lever, 1998; Leach, 2008; Maddick, 2007; Moran, 2005). Many osteopaths maintain that the original concepts developed by Sutherland are still as valid today as they were 70 years ago, whilst others believe that his theories go against fundamental anatomical and physiological knowledge.

Then there are those who believe that OCF has no place in the osteopathic scope of practice believing its clinical effectiveness is solely a placebo effect (Hartman, 2005, 2006). This argument is only strengthened by studies proving poor interexaminer reliability and a lack of quality empirical research. As noted by Maddick (2007), however, “it is illogical to object to clinical practice because of a lack of evidence” (p. 80). Indeed, it has been suggested that randomised controlled studies have no real meaning in a clinical context, and that research needs to be combined with the holistic practice that is osteopathy (Ferguson et al., 1998; Leach, 2008).

It seems many osteopaths are willing “to question the old dogma” (Ferguson et al., 1998, p. 36) and believe that the osteopathic profession needs to work toward an updated body of understanding. Arguably it is not an issue of whether the CRI exists but rather, what it is and what implications this may have on osteopathic diagnosis and treatment (Chaitow, 2005; Ferguson, 2003). Moran (2005) suggests that these ideas should be explored with the collaboration of leading educators and experts within the OCF discipline.

The influences that shape the opinions and practices of osteopaths in relation to osteopathy in the cranial field

To the best of my knowledge there was no research available at the time of writing up this project that had investigated the influences that shaped the opinions and practices of osteopaths in relation to OCF. It seems clear that the profession is polarised by the OCF debate. Despite this the use of OCF remains strong in New Zealand and because of this further research into the debate is warranted (Chaitow, 2005; Ferguson, 2003; Leach, 2008; Maddick, 2007; Moran, 2005).

Summary

Osteopathy in the cranial field is a controversial modality within the osteopathic profession. There is much literature describing both the phenomena associated with OCF and the principles and philosophy of OCF. There is, however, a lack of a cohesive, evidence based explanation for the described mechanism, and research has yet to prove its efficacy as a modality. Perhaps this influences the opinion that OCF has no place within the scientific practice of osteopathy, but the reality is that the popularity of OCF is demonstrated both anecdotally and

within literature. Therefore, to advance the understanding of why there are such differing opinions about OCF it is necessary to begin to explore the influences that shape these opinions. Research of this kind will provide insight into the motivations and behaviours that are associated with these opinions, which could help inform future discussions about OCF.

CHAPTER THREE – METHOD

Introduction

This chapter describes the methodology and method used in the study. The methodological processes including, sampling, data collection and analysis, ethical considerations and the steps taken to ensure the credibility of the study, are all detailed in the following sections. Finally notes on reading the presentation of findings and discussion chapters are provided for greater ease of reference when reading these sections.

Methodology to method

The methodology adopted for this project was a qualitative approach using thematic analysis. A qualitative, exploratory methodology allowed the opportunity to gather “rich information” (p. 107) from the participants aiding the development of meaningful thematic relationships (Schneider, Whitehead, Elliott, Lobiondo-Wood & Haber, 1999). When examining literature for the study it became evident that the influences that shaped osteopaths’ opinions about OCF were under-explored. For this reason an interpretive descriptive method was chosen to generate information on the research topic. Interpretive description is inductive, helping to build from a specific observation, in this case the controversial issue of OCF, toward broader generalizations and theories. This is an essential process when there is a lack of relevant information on a topic (Thorne, 2008; Thorne, Kirkham & MacDonald-Emes, 1997; Thorne, Reimer-Kirkham & O’Flynn-Magee, 2004).

To further develop the information on this topic, focus groups were employed as they are an effective way to capitalize on group processes to generate social knowledge, such as the beliefs and attitudes that underlie a behaviour (Krueger & Casey, 2000; Schneider et al., 1999; Thorne, 2008).

Individual interviews with 'key informants' also helped to generate information. Key informants are members of the community who are better equipped to inform the researcher of what is happening and why, such as persons with particular expertise and leading educators (Thorne, 2008).

Research method

The following section outlines the processes used to complete this study, including data collection, handling, and analysis. An explanation of the processes involved in interpretive description, as informed by Thorne (2008), is also provided.

Sampling

Two methods of sampling were used for this study. The first sampling method was convenience sampling. Convenience sampling was an appropriate method of sampling as this study was a small study, in the earliest stages of describing a phenomenon (Krueger & Casey, 2000; Schneider et al., 1999; Thorne, 2008). Convenience sampling was used in three ways. Firstly all osteopaths identified as working in the Auckland region by the Osteopathic Council of New Zealand's database of registered osteopaths, were contacted by phone. Only osteopaths who had been registered with the Osteopathic Council of New Zealand for at least two years were called; to ensure that any potential participant met the criterion of having practiced for a minimum of 2 years. If an osteopath could not be contacted a message was left with administration or by answering message. If contact was not possible after two attempts the osteopath was removed from

the calling list. Only one participant was recruited in this manner; this was not an effective way to recruit participants for the study.

Secondly, convenience sampling was used to access osteopaths who were attending the Osteopathic Society of New Zealand's Biannual Conference, which was held in Auckland on the 13th to 15th of September 2009. Emails were sent on my behalf to the conference attendees by the Osteopathic Society of New Zealand, introducing the research topic and myself. The attendees were asked to contact me if they were interested in participating in the study. All replies from the conference attendees were screened using the Osteopathic Council of New Zealand database to confirm if the possible participants had been registered for at least 2 years. Seven participants were recruited from the emails sent to the conference attendees.

Finally convenience sampling was used to contact osteopaths who were known to the researcher in a teacher-student relationship. These participants were both past and present tutors and lecturers and could have been recruited in the convenience sampling from the Osteopathic Council of New Zealand list. My relationship with these participants was not considered an exclusion criterion due to the small population of osteopaths in Auckland their exclusion would have severely limited the study. Five participants were recruited who were known to the researcher in a teacher-student relationship.

The second sampling method was purposive sampling, this was used to recruit participants who met the criteria of 'key informants'. In this study key informants were osteopaths who were generally considered to be leading osteopathic educators, and experts in the OCF field. Two key informants were identified and participated in this study.

Participant selection

Information sheets were supplied either by email or in person to osteopaths who expressed interest in participating in the research project (see Appendix A). Once they had read the information sheet, and they wished to proceed, they were

given the set of screening questions (see Appendix B) developed by the researcher for the purposes of this study. These were used to allocate the participants into one of three focus groups:

1. Having strong opinions against OCF (FGA)
2. Having neither strong opinions for nor against OCF (FGN)
3. Having strong opinions for OCF (FGF)

The set of screening questions consisted of six strong statements, three for and three against OCF; participants were supplied with five Likert scale response options. These six screening question statements were developed in consultation with three qualified osteopaths and were designed to provoke a variation of responses. During consultation some changes were made to the original statements before proceeding with participant recruitment for the study.

The positive statements were scored as follows:

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 4 | 3 | 2 | 1 | 0 |

The negative response values were scored inversely as follows:

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 0 | 1 | 2 | 3 | 4 |

The response scores were then tallied as follows:

1. Having strong opinions for OCF 18-24 points
2. Having neither strong opinions for nor against OCF 9-15 points
3. Having strong opinions against OCF 0-6 points

An additional two questions, designed to elicit support of the findings from the above screening questionnaire were also asked. These questions were developed to ensure that the group selection process was accurate. The questions were:

1. Briefly what do you think of osteopathy in the cranial field?
2. How often would you use osteopathy in the cranial field? (i.e. every patient, most patients etc.)

Originally participants were to be allocated into one of the focus groups depending only on their questionnaire score. When the screening questionnaire was given to those who had a negative or neutral opinion of OCF, it was found they did not fall into the category they felt they identified with. For this reason an additional question was added to the questionnaire to ensure they were allocated into the appropriate group. The question was as follows:

1. Which group do you feel you have the greatest affinity to?
 - Strong opinions against OCF
 - Neither strong opinions for nor against OCF
 - Strong opinions for OCF

In the event that the participant did not agree with the grouping that their score allocated them to, this question determined the group that they would choose to participate in. The reasons for this are discussed in Chapter Five.

Sampling processes were to continue until approximately six participants were recruited for each focus group as this number is considered to be an ideal size for focus groups (Krueger & Casey, 2000; Thorne, 2008). After all possible contacts

had been approached the groups had to be undertaken with smaller numbers. The final numbers for the groups were; Focus Group A three participants, and Focus Groups N and F four participants each.

The key informants recruited for this study were not required to complete the screening questionnaire. The reason for this was that the key informants were approached because they were known within the osteopathic community to have a particular opinion about OCF. This was confirmed through a short conversation with the practitioner when inviting them to participate as a key informant for the particular side of the debate; strong opinions for, or against, OCF.

All participants signed a consent form (see Appendix C) before participating in this research project and were invited to ask any questions about the project.

Sample

A total of eleven osteopaths participated in three separate focus groups and two key informants were interviewed separately. The groups are described in detail at the end of this chapter.

Inclusion Criteria:

All participants enrolled in the study had to satisfy the following inclusion criteria:

- Be registered with the Osteopathic Council of New Zealand.
- Hold a current Annual Practicing Certificate.
- Have a minimum of 2 years osteopathic practicing experience.
- Be willing to openly discuss their views within a focus group or interview.

Data collection method

Semi-structured focus groups were the primary method of data collection chosen for this study. Focus groups were employed as they helped capitalize on group processes to generate knowledge on the relatively under-explored topic (Krueger & Casey, 2000; Litoselliti, 2003; Thorne, 2008). Semi-structured individual interviews were also chosen as an additional method to collect data. Both methods of data collection were appropriate for the study as they facilitated engagement with the topic (Krueger & Casey, 2000; Thorne, 2008). The type of data gathered comprised views, attitudes, beliefs, opinions, motivations and perceptions to help determine why osteopaths feel the way they do about OCF. The semi-structured focus groups and interviews allowed a degree of flexibility when responding to the information that was provided by the participants. This was important as the research topic is poorly understood and there was no way to predict what themes may have emerged during the focus groups and interviews (Krueger & Casey, 2000).

Individual interviews were held with the two key informants. The key informants were chosen through professional networks within the osteopathic community. The key informants were identified as having extended experience either with OCF research or their own practice of OCF. They were interviewed separately from the focus groups because of their extended experiential knowledge, which could provide further insight on the debate that would be best captured in an interview setting. This also reduced any risk of the other participants feeling intimidated by the key informants' experience.

To help guide the discussion a questioning route (see Appendix D) was prepared for each focus group and individual interview as suggested by Krueger and Casey (2000). The questions were aimed at triggering thoughts or memories about how the osteopaths' opinions of OCF developed and also to ensure consistency in questioning between the groups.

Data collection process

The focus groups and individual interviews were recorded using a digital recorder. An observer tracked the dialogue in all focus groups. The observer was a person who had previous experience in conducting focus groups and was selected because of this experience. They were identified through Unitec research networks. The observer was instructed to note the name and order of the speakers as conversation progressed throughout the focus groups. This made it easier to identify the speaker when listening to the voice recordings and allowed the facilitator to engage fully in the conversation (Thorne, 2008).

Focus groups and individual interviews ranged in length from 50 minutes to 75 minutes. All participants were physically present at the focus groups with the participants arranged around a table to ensure that they could all hear and see each other. The individual interviews were also conducted in person.

Data analysis method

An interpretive thematic analysis was used to interpret the data and identify the themes, associations, relationships, and patterns that arose from the focus groups and interviews. This was achieved through data comprehension, meaning synthesis, relationship theorizing, and recontextualization of data into findings (Thorne, 2008; Thorne et al., 2004).

The data analysis was transcript-based using transcripts of the focus groups and individual interviews (Krueger & Casey, 2000). I personally transcribed the recordings as Thorne (2008) suggests this allows the researcher to “hear more deeply” (p. 143) what the participants have said. Each focus group/interview took between six to ten hours to transcribe. Additionally, I kept a journal throughout the research process, which was particularly important when transcribing as it provided a record of the thought processes that later helped inform the thematic analysis. It was quite early in the data analysis that what became the final themes began to emerge.

After reading the transcripts several times, I identified and 'flagged' significant sections and phrases that were potentially relevant to the research topic. These were then loosely organized into groups of data that had both similar and dissimilar properties. Care was taken to avoid any formal coding system at this point as Thorne (2008) suggests that premature coding can hinder the analytic process.

The final process of thematic analysis began by replaying the recordings of the focus groups and individual interviews, listening to tone and inflection, which helped preserve the conversation meaning whilst re-reading the transcripts. Possible themes were then listed first under separate titles, Focus Group A, N, F; each with supporting quotes from the transcripts. The emerging themes from each group were then compared to identify any repetition or recurring themes across the groups with the intention of identifying the main messages that had emerged from the data (Thorne, 2008). As Thorne (2008) suggests these emergent themes were then considered along side literature reviewed for this study. After recontextualisation thirteen themes were identified. When these were reviewed it became apparent that these could be represented by three overarching influences. These influences form the basis of the presentation of findings in Chapter Four. The themes were thus organized within these overarching themes depending on which overarching theme I felt had the greatest bearing on it.

Ethical considerations

An application for ethics approval was submitted to the Unitec Research Ethics Committee and the study approved from the 27th of May 2009. The application addressed ethical issues pertaining to this study, which included informed consent, privacy, confidentiality, anonymity, withdrawal from the study and

avoidance of conflict of interest. There was no foreseeable harm associated with this project, however, consideration was given to the following issues:

Informed and voluntary consent

Potential participants were given an information sheet and an invitation to participate in the study. The information sheet described the study, the purpose of the study and the future uses of their contributions (see Appendix A). If the osteopaths agreed to participate they were then asked to sign a consent form (see Appendix C).

Because the focus of the inquiry was human, subjective, experiential knowledge the researcher could not fully determine what would happen in the research encounter (Krueger & Casey, 2000; Thorne, 2008). Informed consent was, therefore, an ongoing moral obligation of ensuring that the participants revealed only what they were comfortable with and no more (Krueger & Casey, 2000; Litoselliti, 2003; Thorne, 2008). Participants were not pressurised to speak and were not asked to reach a consensus. Due to the nature of the research topic, sensitive information may have been revealed during the focus groups or individual interviews and for this reason participants were sent a copy of the transcript from their focus group or interview and had the opportunity to edit or withdraw any or all of their statements from the transcript. Having had this opportunity none of the participants withdrew or changed any of their contributions, however, one participant did make a minor addition to one of his comments to further clarify his point.

Withdrawal from the study

The participants were able to withdraw from the study at any time up until two weeks after they received the transcript from their focus group or interview for review. Two potential participants withdrew from the study before the focus group they were to participate in was held.

Respect for rights, confidentiality and preservation of anonymity

A particular issue to consider in focus group research is confidentiality as the nature of focus groups is such that absolute anonymity cannot be preserved (Krueger & Casey, 2000). As the moderator, I discussed the importance of confidentiality with the participants prior to conducting the focus groups. They were asked to keep the names of those who participated and what was discussed within the focus groups strictly confidential.

In this thesis all participants' names and information that may have identified them has been kept confidential, respecting their right to anonymity. For this reason the participants have been given pseudonyms that are detailed at the end of this chapter.

All information has been stored securely on a password protected computer and in hard copy in a locked filing cabinet at the researcher's office. Secure storage will be maintained for a minimum period of 5 years as per Unitec protocols, before secure destruction.

Avoidance of conflict of interest

The theoretical allegiance of the researcher on entering the study may be seen as a conflict of interest. For this reason I documented my 'positioning' on the issue prior to data collection. This helped me to understand my personal motivations, and biases before I heard what the participants had to say. The importance of this process and how I worked with this 'positioning' throughout the research process is discussed in Chapter Five.

The question of credibility

Because the data sought for this research project was human subjective experiential knowledge and the nature of qualitative research is emergent it is

vital to the credibility of the study that attention be paid to the rigour of the processes and reporting involved (Sandelowski, David, & Harris, 1989; Thorne et al., 1997).

Throughout the research process I endeavoured to demonstrate a clear audit trail by outlining the processes involved; including participant selection, data collection and data analysis. This ensures that the steps taken throughout the research process can be examined for credibility (Thorne et al., 1997).

Although Thorne et al. (1997) suggest that trying to eliminate all bias in qualitative research is “naïve” (p. 175) thorough attention was paid to reduce the effect that bias had on the findings. Before beginning data collection my theoretical allegiance was documented so that I could acknowledge my ‘positioning’ and personal bias when interpreting the data. This also helped inform Chapter One where my interest in the debate about OCF was outlined to demonstrate the transparency of my intentions.

After data collection participants were invited to review their transcripts from the focus groups and individual interviews. This ensured that what was transcribed was an accurate representation of what the participants had said, and enabled them to make changes or provide further clarification if necessary. Therefore, the data was confirmed as being true and reliable before data analysis began. Once the final transcripts were accepted these were read and re-read so that I could immerse myself in the data and have greater understanding of the information gathered. Emergent themes were then identified using excerpts from the transcripts to ensure that the themes remained within their context.

“Because an interpretive description is intended to extend beyond what any individual might “see”” (Thorne et al., 2004, p. 17) the findings of the analysis were presented to my research supervisors at various stages throughout the analytical process and to colleagues at a research forum for feedback on the developing themes.

Additionally the proposed themes were presented to a senior osteopath who has

considerable knowledge of the debate for expert review. He determined that the findings were not only plausible but that they also confirmed many of his experiential 'hunches' on what influences osteopaths' opinions and practice of OCF. This confirmation added to the integrity of the findings and the overall credibility of the study.

Summary

This study was an exploration of the influences that shape the opinions and practices of those who do and do not practice osteopathy in the cranial field. Because this area is relatively under-researched focus groups were chosen because of their ability to generate social knowledge (Krueger & Casey, 2000). Individual interviews with key informants were used as these participants had extended experiential knowledge on the subject that could be seen to provide further depth to the findings of the focus groups.

Thirteen individuals participated in data collection for the study, which included three semi-structured focus groups and two individual, key interviews. A questioning route was used for both the focus groups and individual interviews to ensure consistency in questioning whilst maintaining the possibility for new relationships or understandings to emerge that had not been considered.

The data analysis method for this study was based on an interpretive descriptive method (Thorne, 2008). After thorough analysis of the transcripts from the focus groups and interviews, themes were identified and presented under three overarching influences.

Ethical consideration was given to the areas of anonymity, informed and voluntary consent, the ability for participants to withdraw from the study and avoidance of conflict of interest.

Credibility and the application of rigour were demonstrated through the clear audit trail outlined in this research project. Prior to data collection theoretical allegiance was documented, as was the personal interest in this study to acknowledge that the actions and thoughts of a researcher will affect the nature and outcome of the enquiry. By understanding this concept the researcher can better understand their biases and therefore add to the credibility of their research (Thorne, 2008). To ensure that the transcripts used for the data analysis were accurate, participants were invited to review their transcripts. Finally the themes were presented to a senior osteopath who confirmed that these were indeed plausible from his experience.

In the next chapter the findings from the data analysis are presented. These findings are described and interpreted using quotes from the transcripts.

Notes on reading the study

Throughout the next two chapters excerpts from the focus group and interview transcripts have been used. The excerpts are italicised and referenced using the name of the participant who said them and the focus group or interview that the participant had been part of. These group names have been abbreviated for ease of reference.

For the purposes of confidentiality the participants have been given gender-correct pseudonyms. A basic description of each participant has also been included that highlights the practitioner's osteopathic experience and a general description of how the practitioner chooses to practice.

Additionally when a group is referred to as Group A or Group F it includes the key informant, when it is referred to as Focus Group A or Focus Group F it does not include the key informant who may have had an opposing or different opinion.

Focus Group A (FGA) – Strong opinions against OCF

Clint: a practitioner with twenty-four years experience as an osteopath who has a strongly structural approach to treatment and never uses OCF.

Sean: a practitioner who uses both structural and functional approaches to treatment including treating the cranial bone articulations, but does not use OCF. Sean has been practicing for 19 years.

Andrew: a practitioner with fourteen years experience as an osteopath who uses a strongly direct approach to osteopathic treatment and never uses OCF.

Focus Group N (FGN) – Neither strong opinions for nor against OCF

Mike: a practitioner with five years experience who practices using a variety of treatment modalities. He describes himself as using OCF very occasionally (i.e. one patient per week).

James: a practitioner with three years experience who uses OCF when required by the patient's presentation and/or wishes.

Karl: a practitioner with thirteen years experience who practices using a variety of treatment modalities including using OCF with approximately half of his patients.

Richard: a practitioner with eleven years experience who uses a variety of treatment approaches including OCF very occasionally.

Focus Group F (FGF) – Strong opinions for OCF

Brian: a practitioner with nineteen years experience as an osteopath who practices using predominately OCF.

Sarah: a practitioner with seven years experience who uses OCF with every patient but also uses a variety of other techniques.

David: a relatively new practitioner with two years experience as an osteopath who would use OCF with every patient but also uses other modalities.

Tony: a practitioner with fifteen years experience who considers himself an OCF practitioner.

Key Interview A (KIA) – Strong opinions against OCF

Jason: a senior osteopathic lecturer who plays a significant role in osteopathic research who does not use OCF.

Key Interview F (KIF) – Strong opinions for OCF

Jack: an osteopath with twenty-three years of practice. He primarily treats patients using the OCF modality.

CHAPTER FOUR – PRESENTATION OF FINDINGS

Introduction

In this chapter the findings from the interpretive analysis of the three focus groups and two individual interviews are presented. During the analysis phase of this research project many influences emerged from the data. Three themes represent the findings and were identified because they best illuminate the influences that shaped the participants' opinions and practices in relation to osteopathy in the cranial field.

The first theme was titled '*me*' and refers to those influences that have been shaped by factors intrinsic to the individual; these are; the experience of great job satisfaction, achieving positive patient outcomes and the belief that treatment should be about the patient not the practitioner.

The second theme '*it*' describes those influences that are related to the perception of OCF as a modality, these include; research reflecting negatively on OCF, the opinion that OCF is not osteopathic, that the OCF modality is overcomplicated and inaccessible, the belief that OCF is just another tool in the toolbox, and from the opposite side of the debate; that OCF just makes sense and that it is OCF carrying the profession forward.

Finally the third theme '*they*' illustrates the influences that can be attributed to others and at times their actions, these are; that OCF practitioners are dogmatic, that the ego gets in the way of OCF practitioners, that OCF practitioners are jeopardising the profession and conversely that OCF practitioners are great role models.

Some of the influences could have been categorised under more than one of these themes. When this occurred the influence is presented in the group believed to have had the most effect on it.

‘Me’ – How intrinsic factors influenced the participants

This theme describes how the different individual beliefs and needs of the participants influenced their opinions and practices in relation to OCF. Three sub-themes were identified. These were; ‘osteopathy in the cranial field gives me great job satisfaction’, ‘osteopathy in the cranial field gives me great patient outcomes’ and ‘it should not be about me, it should be about the patient’.

‘Osteopathy in the cranial field gives me great job satisfaction’

To maintain job satisfaction a position must be engaging and interesting and this was something that participants in Group F (strong opinions for OCF) mentioned repeatedly as having a major impact on why they chose to practice OCF. Kleinbaum (2009) found that boredom with osteopathic practice was a significant factor in why some osteopaths chose to leave the profession. The participants in the study found that due to the repetitive nature of the job they had become bored and were not satisfied with practice life as an osteopath (Kleinbaum, 2009).

Tony discussed how OCF provided a degree of diversity that enhanced his practice experiences. He explained:

OCF has enriched both my professional life and my personal life in many ways. It's opened the door to enable me to work with patients that I would never have imagined I would have been working with when I first began studying osteopathy... it's an

intensely satisfying kind of treatment, it's a beautiful way of spending your day with people. (p. 2, FGF)

The participants indicated that the nature of OCF was such that they never knew what was going to happen in any one treatment. There was always an element of the unknown which practitioners found intellectually stimulating and exciting. For Sarah, this was an important influence on why she continued to practice OCF:

I think the thing is with cranial work is it's ever evolving... you become even more animated and excited about the whole thing year after year after year... whereas if you're looking at the spine, cracking it, articulating a joint, and chucking them out I can imagine it becoming incredibly tedious. And that's not what we do; I mean osteopathy is an art, there's a passion involved in doing it. For me OCF plays a major part in that excitement and enthusiasm at getting better every year. (p. 10, FGF)

This passionate description of how OCF enhanced this practitioner's life was representative of the opinions expressed by all five of the participants from Group F. For these participants OCF was not just a profession, but something they did because it enhanced their lives; they did not work to live, but lived to work. It seemed they used OCF in their practice of osteopathy as much for themselves as they did for their patients, explaining how the very process of treatment was restorative for the practitioner. This could possibly reduce the risk of burnout, which has been well documented amongst healthcare workers including osteopaths and is a common reason why practitioners leave their profession (Kleinbaum, 2009; Scutter & Goold, 1995; Wolfe 1981).

All of the elements described above have combined to fill these osteopaths with a sense of job satisfaction and this has ultimately contributed to their positive opinion and practice of OCF.

'Osteopathy in the cranial field gives me great patient outcomes'

No matter what modality an osteopath uses the aim of treatment is the same: to decrease the patient's symptoms and improve their quality of life. There are, however, many ways in which to achieve positive patient outcomes and different osteopaths will approach treatment in different ways.

For participants in Group F, one of the profound influences on their opinion of OCF was the positive results they achieved using the OCF modality in their practices. For Tony, positive patient outcomes equalled happy patients and business success, as he said: *"you wouldn't continue if your patients weren't happy. You would have no choice; if you weren't getting results then you would be out of business"* (p. 11, FGF). Tony touches on an important component of the anecdotal evidence supporting the use of OCF: if OCF were an ineffective treatment why would so many OCF practitioners continue to attract paying patients? Often osteopaths do not advertise their services but instead rely on referrals and word of mouth. Successful patient outcomes may, therefore, be a significant determinant of business success, which could then influence practitioners' use of the OCF modality. It could be argued, however, that there is little evidence supporting the claim that popularity of a treatment modality demonstrates that it is effective.

When key informant Jack started using OCF he was trying to find a treatment that would set him aside from the other osteopaths in his city. He was amazed when he started to have success with patients who had chronic health concerns, despite seeing many different practitioners with little or no success. These positive patient outcomes are a major contributing factor for why Jack has a largely OCF based practice today. Another influence that shaped Jack's opinion of OCF was the way he felt as a practitioner when his patients had these positive responses to treatment: *"The heart responds to the joy of being able to facilitate, observe and watch people move from dysfunction towards health... it's just an indescribable joy to see people getting better"* (p. 5-6, KIF).

Considering the successful patient outcomes that these practitioners experience it is not surprising that they have continued to develop their practice of OCF. As Wolfe (1981) suggests, the ability to successfully resolve patients' issues is a major contributing factor to job satisfaction in healthcare.

'It should not be about me, it should be about the patient'

In current times practitioners are progressively encouraged to have a more patient-centered approach to healthcare, as literature suggests that increasing the patient's involvement in treatment results in greater patient satisfaction (Lewin, Entwistle, Zwarenstein & Dick, 2001). Group A (strong opinions against OCF) were concerned that OCF was, as they described, a largely practitioner-centred treatment modality. The participants alluded to the considerable body of evidence supporting active forms of treatment "*the evidence in healthcare is pretty convincing that active forms of treatment are better than passive forms*" (p. 12, KIA). Key informant Jason discussed the ramifications of the passive nature of OCF treatment:

I have some concern about how passive OCF is for the patient... I don't think that's a healthy form of rehabilitation. In fact it creates dependency and it lends itself to dependency. The locus of control comes away from the patient onto the practitioner, the practitioner determines what happens, the collaborative approach to recovery and healthcare is not there. (p. 12, KIA)

Also in relation to the "*locus of control*" the participants in Group A believed that there was a lack of feedback from patients, suggesting that what an OCF practitioner gauges as a positive (or negative) treatment response may be very subjective. For Group A this further supported their beliefs that patient involvement in treatment which is a vital part of the therapeutic process is missing in OCF treatments.

There was also criticism from both Focus Groups A and N (neither strong opinions for or against OCF) that there was a lack of explanation to patients

about what an OCF practitioner is doing during treatment. The participants challenged whether OCF practitioners were truly getting 'informed' consent from their patients during treatments. The New Zealand Health and Disability Commissioner Act (1994) stipulates that no health care procedure be carried out without informed consent (The Health and Disability Commissioner Act 1994, s 20). Informed consent is a vital part of osteopathic education and students must learn to maintain open communication with their patients throughout treatment; a practitioner for example should tell a patient of their intention to begin treating an area of the body. Mike explained how he believed that many OCF practitioners did not communicate this to their patients:

The underlying foundation of what I was taught is that you can't treat without consent. So if you are trying to diagnose or treat something and you are not informing the patient; you are looking around their body and doing a little bit over here on their lung or liver or whatever, you must be telling them that. You can't just go off doing things or bring in spirituality without informing them. That is where their consent has to come in. (p. 19, FGN)

Mike is referring to the fact that OCF practitioners may treat other parts of the body for example the pelvis, but with their hands on the head of the patient. He was concerned that the OCF practitioner may not be telling the patient what part of the body they are treating; in which case there may be a consent issue. This raises a question about whether consent must be gained to treat an area of the body if you are not actually coming in physical contact with that area? This is a complex question and it is difficult to determine how much a patient needs to know about the treatment they are receiving. It would be of interest to know if patients would think differently about their treatment if they knew what the practitioners were treating or perhaps some of the philosophies behind OCF treatment such as the 'breath of life'. This was, however, beyond the scope of this project, but nonetheless served to illuminate the serious concerns of some osteopaths.

The passive nature of OCF and the perceived lack of open communication between patient and practitioner during an OCF treatment had an impact on how Group A and N felt about OCF. Underlying these opinions were the participants' belief that osteopathic practice should not be about 'me' as the practitioner, but about the patient. This demonstrated that there was a relationship between a participant's intrinsic beliefs about osteopathy and the development of their opinions about OCF.

***'It' – How the perception of osteopathy in the cranial field
as a modality influenced the participants***

This theme described influences that were shaped by the participants' perception of OCF as a modality. Six sub-themes were identified. These were; 'previous research reflects poorly on osteopathy in the cranial field', 'osteopathy in the cranial field is not osteopathic', 'osteopathy in the cranial field is overcomplicated and inaccessible', 'osteopathy in the cranial field is just another tool in the toolbox', 'osteopathy in the cranial field 'just makes sense'' and 'it is osteopathy in the cranial field that is carrying the profession forward'.

'Previous research reflects poorly on osteopathy in the cranial field'

There is an increasing demand for the accountability of osteopaths from within the profession, from the public and from regulatory bodies such as the Osteopathic Council of New Zealand. This has put more pressure on osteopathy to conform to an evidence-based model, in which practice is based on those techniques or treatments that are supported by credible research.

Although many osteopaths believe these changes are necessary for the development of the profession, others believe that evidence-based practice (EBP) compromises their freedom (Baer, 2009). Indeed Leach (2008) has highlighted that the debate about EBP has itself polarised the osteopathic

profession, particularly in relation to OCF. It is, therefore, no surprise that the unfavourable results of OCF research such as the interexaminer reliability studies conducted by Moran and Gibbons (2001) and Sommerfield et al. (2004) have influenced the opinions of Groups A and N. James, for example, found that the lack of a cogent explanation for these poor results did not look good for OCF:

Whilst every osteopath will be slightly different if you ask us to find a restriction in a neck, chances are I will tell you that it's the same segment as another osteopath. Whereas somebody having done that same study with OCF, with the same amount of simplicity, just feeling the cranial rhythm, looking at its speed, its quantity, its intensity, no one can agree. If we are thinking that it is a natural biological rhythm comparative to heart rate or breathing rate then we should all be able to feel the same thing and at the moment we can't. (p. 10, FGN)

The general consensus within Group N was that there needed to be a push towards development of a greater body of research into controversial modalities like OCF. They suggested that there was a lack of clarity on what research was needed in this field. As Mike said about EBP:

Unfortunately it's the way our profession has to head if we want to stay with the mainstream and be accepted, and I am not saying that cranial can't be evidence based practice. We just have to define what evidence is and write a research paper to show it. (p. 9, FGN)

It was clear that the participants from Groups A and N considered the research conducted into OCF thus far discouraging, which negatively affected their opinions of OCF.

When Group A was questioned about the effect of previous OCF research on their opinions they all agreed that it powerfully influenced their negative opinions of OCF. Focus Group A believed that research had illuminated

discrepancies in the OCF modality that were not acceptable for a primary healthcare profession, and for this reason two members of this group suggested that OCF should be removed from the osteopathic scope of practice. As Sean said:

The physiological experiments aren't sensitive enough to be able to explain what some primary respiratory mechanism might be. And so, because we are flailing around in the dark I feel that it shouldn't really have the epithet of osteopathy at this point. (p. 8, FGA)

Participant responses were congruent with literature reviewed for this project that suggests a lack of favourable results from research is a major influence on those who have negative opinions of OCF (Hartman 2006, 2007; Maddick, 2007, Moran, 2005).

'Osteopathy in the cranial field is not osteopathic'

As outlined in Chapter Two, the scope of practice for osteopathy is not well defined and may encompass all techniques and treatments that are taught in an accredited college. This would suggest that these techniques and treatments are therefore 'osteopathic', but Group A did not agree. They believed that despite OCF being permitted under the scope of practice, it was not osteopathic, which strongly influenced both their negative opinions of OCF and their decision not to practice OCF. Clint said: *"I think OCF is an oxymoron, I don't think it's osteopathic at all. I don't think it follows any of the fundamental ideas put forward by Still, although that would be disagreed."* (p. 1, FGA). Clint's statement demonstrates that an osteopath's opinion about what osteopathy is will affect their opinion of different modalities such as OCF. This concept raises the following questions; what does 'osteopathic' mean? And what shapes a practitioner's opinion about this? It is possible that Clint's education was a major influence in this instance and that the education provider would play a significant role in what osteopaths perceive 'osteopathic' to mean. All of the participants from Group A had attended educational institutes with strong structural curricula and in response

to a question about whether education affected their opinions of OCF they all agreed that it had influenced their negative opinions in some way.

Because members of Focus Group A did not believe OCF to be 'osteopathic' they would prefer to see OCF removed from under the umbrella of osteopathy and in fact Andrew was willing "*to make it a lifetime work to get it removed from osteopathy*" (p. 6, FGA). Emotive statements like this are not solitary instances with similar sentiments being expressed by the likes of Hartman (2006, 2007) and Ferré and Barbin (1991). Comments like this also demonstrate that this debate is a very important issue for osteopathy as a profession, and raises questions about the current scope of practice.

Key informant Jason agreed that debate about whether OCF should be part of the osteopathic scope of practice was a pressing issue for the osteopathic profession as a whole. This seems, however, to be a more complicated issue, and is not just about the OCF versus structural debate. Andrew for example was concerned that there was no standardisation within the profession and that this was confusing for patients, saying:

One of my biggest complaints about the profession, you don't know whether you are going to get someone leap all over you and crack every bone in your body or someone hold your head for half an hour. It is really bad! Very bad. (p. 20, FGA)

For Andrew, perhaps the scope of osteopathy was too broad. Reformation of the scope of practice in New Zealand is currently on the agenda of the Osteopathic Council, the regulatory authority for the profession. The chair of the Council states, however, that "Scope of practice statements will always be somewhat imperfect, or a work-in-progress or simply not an exact fit with one's own views" (Osteopathic Council of New Zealand, 2010, Foreword, para 2). This is a complex issue and it is difficult to comment on this further as this goes beyond the remit of this study.

'Osteopathy in the cranial field is overcomplicated and inaccessible'

When evaluating competing explanations such as the theory behind the cranial rhythmic impulse, simpler explanations are judged both better and more likely to be true (Lombrozo, 2007). Key informant Jason believed that OCF was made to be far more complicated than it ought to be, alluding to the popular interpretation of the principle of Occam's razor that the simplest explanation is usually the correct one. Jason had a negative opinion of OCF because OCF failed to follow this principle instead using elaborate models to explain its action. Jason said:

If we can develop a nice simple explanation for why people respond to holding onto their head lightly and spending time, if a trial came out to show that the non-specific elements were as effective as the ones where you have to be really trained up, then why do the training? Why should we waste resources and money and time and sweat and effort? (p. 6, KIA)

Historically the models used to explain OCF have been complicated, and this has been a common criticism of OCF (Jones, 2000; Leach, 2008; Maddick, 2007; Patterson, 2000). Interestingly, Jason mentioned that he had seen a number of unusual positive treatment responses from OCF, he said:

I haven't seen a lot but there are some treatments where you get the sense that it's not a chance improvement. Here you have been struggling along for a period of time with this disorder; you know, it's poor, it's poor, it's poor... and then you have this session with someone who does something to you and you're better, way better and this is not a coincidence thing. It coincides with the treatment so you can only attribute the change to this treatment... so you see a couple of those and you think there may be something in this. (p. 3, KIA)

Based on this experience, Jason could not completely discount OCF as a therapeutic modality despite having strong negative opinions of OCF. His theory about these positive treatment effects was that they were probably due to something much simpler than treatment of some inherent 'primary respiratory mechanism'. Jason was, therefore, very sceptical about OCF, much like the participants from Focus Group A, who agreed that OCF could be explained more simply and with plainer language.

There was also concern about a sort of secrecy, or mysticism, surrounding OCF, which made it inaccessible. The participants from Focus Group A believed that OCF knowledge was sold rather than shared and thus the cost of OCF courses was another reason they had negative opinions of OCF. Historically, OCF courses have been significantly more expensive than other courses offered for Continuing Professional Development. This seems to be causing animosity towards the OCF community and could be reinforcing the sense of inaccessibility associated with OCF. Sean demonstrated this point:

The other thing that I would like to mention as negatively influencing my opinion of OCF is the Sutherland Cranial Teaching Foundation's costs for their courses. Un expletive, expletive, expletive [sic] believable! If they are serious about drawing more osteopaths into that mode of thinking then I think they would certainly by now be able to offer cheaper courses! They appear not to want to do that and that flies in the face of spreading the scientific word. If you have got something to say, generally speaking it goes into a journal; it gets spread to the world. It is not some secret bit of information that you peddle at two and a half thousand bucks a go! (p. 18, FGA)

This statement demonstrates the emotive nature of the debate and on reflection inaccessibility to OCF courses because of high costs was certainly one of the more sensitive topics that was discussed across all three focus groups.

The anger that has developed over this issue is certainly reinforcing the schism between those who do and do not practice OCF.

'Osteopathy in the cranial field is just another tool in the toolbox'

The analogy of OCF being '*just another tool in the toolbox*' (p. 1, FGN, Richard) was a recurring theme throughout Focus Group N and strongly motivated the participants' opinions of OCF. Despite having some reservations about OCF, Group N believed it should be viewed as one technique of many employed as part of an osteopathic approach to treatment. Richard explains, "*Is it not just another tool in the toolbox as they say? It is just some other way to affect whatever you may have decided your working diagnosis is and therefore, just another technique; be it successful or unsuccessful.*" (p. 1, FGN). James found that having a variety of treatment techniques including OCF served him well in his osteopathic practice:

One of the things that made me approach OCF and start treating with OCF was the fact that if you start off with a medium sized toolbox and you suddenly come across a problem in which you believe a particular tool might be very effective, but you haven't got that tool in your toolbox, it makes you think well maybe my toolbox needs to be a bit bigger? (p. 4, FGN)

Osteopathic treatment should always ensure that the patient is treated as a unique individual and that treatment is adapted appropriately, depending on the individual's needs (Ward, 2003). As Mike suggested "*sometimes you need to manipulate and you need to be good at it, sometimes you need to do cranial... and there is a spectrum of techniques in between.*" (p. 4, FGN). Theoretically, the more treatment options a practitioner has, the more they can adapt and cater for a wide variety of patients and complaints. James found that his ability to adapt because of a well-equipped toolbox meant that he was more successful in his treatments. The opinion of Group N about OCF was that it is a useful technique when indicated, and this was largely influenced by the need to have a variety of

approaches available in their practices. As James quite aptly explained “*there is no point putting in a screw with a hammer*” (p. 4, FGN).

‘Osteopathy in the cranial field ‘just makes sense’

Unlike the participants from Focus Group A, who did not think OCF was osteopathic, participants from Focus Group F saw OCF as an osteopathic approach to diagnosis and treatment just like any other. The fundamental difference between why they chose to practice primarily using OCF and not another modality is that it resonated with who they wanted to be and how they wanted to practice; OCF was a good fit for them. Brian said:

When I first heard about it, it seemed to be the most natural thing to do, the most natural way to treat the body. It’s a nice simple form of treatment... a straightforward logical way to organize health. (p. 4, FGF)

This suggests that a practitioner may intrinsically have a greater affinity towards particular modalities and one could hypothesise that this has a direct relationship with the practitioners’ personality.

In the proposal stage of this research project I had postulated that personality might affect the way osteopaths chose to practice. It became apparent during the focus groups and interviews that some practitioners’ personalities seemed to have had an effect on their opinions about OCF. Sarah, for example, knew very early on in her osteopathic studies that she wanted to be an OCF practitioner:

I had that inherent belief that there is far more to us than we will ever understand. And so going then to study osteopathy, I saw the value in all the other techniques, but there was this real inherent passion to work with something that didn’t necessarily have to make sense at the time. (p. 5, FGF)

That Sarah used the word ‘inherent’ would suggest that going on to practice OCF was characteristic of her personality. When this became apparent from the focus

groups the relationship of practice choices and personality was discussed with both of the key informants. They agreed that particular personalities, beliefs, and attitudes could possibly influence an osteopath's opinion of OCF and therefore ultimately their choice whether or not to practice OCF. This is supported by numerous studies within the medical profession that have researched the relationship between personality and medical speciality choice. These studies suggest there is an association between personality and speciality choice (Borges & Savickas, 2002). It is likely that it is similar for osteopaths; that certain modalities just fit with who the practitioner is as a person.

'It is osteopathy in the cranial field that is carrying the profession forward'

Because OCF is a relatively under-explored modality of osteopathy the participants from Group F believed that there was a lot of potential for OCF in the future; this positively affected their opinions of OCF. As Brian said: *"you know all of the interesting things in osteopathy are happening in the OCF field, all the interesting things... I just think the people who are carrying the profession forward tend to treat cranially."* (p. 9, FGF).

The participant's belief that OCF was carrying the profession forward was supported by the response given by many of the participants from Focus Group F to one of the statements in the screening questionnaire for this research project:

- Osteopathy in the cranial field is the future of osteopathy

Three out of four participants who fit the criteria of having strong positive opinions of OCF 'strongly agreed' with this statement and unsurprisingly this was one of the influences on their opinions of OCF.

The participants from Focus Group F all agreed with each other that OCF was the area where the biggest advancements in osteopathy were being made and this added to their excitement about the future of OCF. They believed that interest in OCF was accelerating whilst much of the structural advancements and interest had slowed somewhat. Participants in Group F thought OCF was going from

strength to strength and this supported their practice of OCF. Interestingly, Group F were not motivated by research and EBP; they did not believe that either was an integral part of the future of OCF.

‘They’ –How ‘others’ and at times their actions influenced the participants

This theme described how ‘others’ (OCF practitioners) and at times their actions influenced the participants’ opinions of OCF and therefore their practice choices. There were two dimensions to the theme ‘they’; first there was the negative, accusatory ‘they’ where the ‘others’ were set apart from the participants. These ‘others’ were seen as doing things that the participants themselves would not do. Then there was the positive, exculpatory ‘they’ where the ‘others’ were seen in a positive way. These ‘others’ were seen as role models. A total of four sub-themes were identified. These were; ‘practitioners of osteopathy in the cranial field are dogmatic’, ‘the ego gets in the way of practitioners of osteopathy in the cranial field’, ‘practitioners of osteopathy in the cranial field are jeopardising the profession’ and finally ‘practitioners of osteopathy in the cranial field are great role models’.

‘Practitioners of osteopathy in the cranial field are dogmatic’

“I don’t think any cranial osteopath who has a really good grip on the field would even think of trying to validate it now. We’ve gone past that.” (p. 18, FGF, Tony).

It would seem that statements like this have had a significant impact on why many osteopaths have negative opinions of OCF. Throughout Focus Groups A and N the unquestioning belief of OCF practitioners was likened to that of dogma. The participants thought that many OCF practitioners blindly believed in OCF, without any evidence to substantiate its use; showing a lack of critical thinking and reflection. This type of belief resembles dogma, an established

belief, or doctrine, which is authoritatively laid down and should not be doubted (Trumble, 2007). The opinion that OCF is a belief system rather than a science is also demonstrated in literature (Hartman & Norton, 2002).

Jason was very concerned that some of these beliefs were *“beyond research”* (p. 4, KIA). He believed that the efficacy of OCF should be *“testable”* and was *“well within the domain of known biological science”* (p.3, KIA). Jason was unhappy with *“blind belief”* being part of a healthcare system like osteopathy (p. 3, KIA).

Dogma is often concerned with extremes of belief or practice and it was the extreme or sole use of OCF that caused the most concern amongst the participants from Group A and N. As Clint said: *“it’s the ones who solely, religiously practice cranial, it’s a dogma and they are completely religious about it, and spiritual, and quite out there, quite strange people.”* (p. 6, FGA).

This idea that some OCF practitioners were practicing in a spiritual or religious manner was a recurring concept throughout not only Focus Group A but also Focus Group N. The majority of the participants in these two groups found this to be completely unacceptable for a healthcare profession, which adversely affected their opinions of OCF. They believed that there was an element of dishonesty in the way OCF practitioners treated, and wondered if the patients were aware of some of the *“bizarre”* (p. 3, KIA) theories behind OCF. Karl thought some OCF practitioners were more like spiritual healers:

They would say they are an osteopath, whereas for me they are more like a spiritual healer. It’s just a problem of honesty, they should say it. I don’t disagree with spiritual healing, but you know trying to hide it behind the whole philosophy of what we do; I find that quite dishonest. (p. 17, FGN)

This sparked an interesting debate amongst Focus Group N, which resulted in Mike asking: *“but isn’t one of our things mind, body and spirit? So you must incorporate the patient’s spirituality, that system can’t be removed from osteopathy.”* (p. 19, FGN). Mike raised an important point and, the ‘triune’

nature of man is an important component of osteopathic philosophy. For the participants from Groups A and N there seemed to be a fine line between an awareness of the spiritual component of health and moving out of the scope of practice into spiritual healing. Jason also mentioned that he had his own spiritual beliefs and that he had no problems with osteopaths having their own personal belief systems. It would appear from Karl's comment that the issue is related to spirituality in the context of healthcare rather than spirituality itself. This was supported by key informant Jason's concern about spirituality in healthcare in relation to government funding. As he said:

Just like we don't allow state sponsored faith healers, you know. There are no state sponsored mystics. If you are in hospital and you want a mystic or a faith healer to come and see you, no worries! But not on the national purse. I think the national purse needs to fund the things that there is evidence for. (p. 19, KIA)

This is a relevant point as some osteopathic patients qualify for funding from New Zealand's accident compensation system the Accident Compensation Corporation.

That OCF practitioners are seen as dogmatic in their beliefs about OCF lends itself to OCF being compared to religion and spiritual practices. Despite spirituality being a negative influence on the opinions of the majority of Group A and N, numerous participants from this study also discussed the importance of spirituality to osteopathy. This included one member of Group N. It seems, therefore, that there is a degree of confusion about where spirituality fits in osteopathic practice.

'The ego gets in the way of practitioners of osteopathy in the cranial field'

"OCF practitioners surround themselves with people who tell them how wonderful they are, they actually believe they are a guru! It's quite scary." (p. 12, FGA, Clint)

The perceived over-inflated ego of many OCF practitioners had a considerable negative impact on the opinions of the participants from Focus Group A, and this was largely due to what was labelled as '*Guruism*'.

A Guru can be any person regarded "as a source of wisdom or knowledge; an influential leader or pundit." (Trumble, 2007, p. 1179). This description would suggest that any modality could have members who have reached Guru status, depending on their level of experience within that modality. The term Guru, however, has an equally negative association of an individual being beyond questioning or doubt. Although some Gurus may be self-appointed others may dislike their Guru status, which has developed due to the opinions of others. This would suggest that to an extent the opinions of Group A are unfair as some OCF practitioners have not chosen to be labelled as a Guru.

Despite this, Group A believed that OCF practitioners fostered this hierarchical order. Andrew explained: "*They mythologize it, they start to create hierarchies, they start to create professors of it.*" (p. 15, FGA). Sean's statement captures the essence of the theme 'they'; the OCF practitioner being seen as an undesirable 'other'. The participants believed OCF practitioners lacked a certain sense of criticality making OCF more like a belief system than a therapeutic modality.

The participants in Focus Group A believed that there was an egotistical attitude or arrogance about OCF practitioners. Clint was angered that many of these practitioners considered themselves to be experts at all:

I have been having a conversation on sacral musings with a guy who decided he wanted to call himself a specialist cranial osteopath. And I wrote and replied saying "can you please tell me what makes you a specialist?", "well I have been qualified ten years, and I have been doing cranial for eight years". And I thought well I have been in practice for twenty-five years and I don't call myself a specialist osteopath, what makes you so good? "We are a speciality profession". What makes them special? It is in their own heads, in their own minds, it is their arrogance. (p. 18, FGA)

There was a sense that Focus Group A thought OCF practitioners believed they were superior to structural osteopaths, and in a lot of ways the participants thought that they used this arrogance as a marketing tool to try and further their business. Group A participants did not think this was fair and thought this self-aggrandising should be banned to allow all osteopaths to appear on the same level to the general public. Perhaps this use of self-promotion by some OCF practitioners is seen as a threat to the income of other osteopaths as it might make the OCF practitioners appear more qualified than their counterparts.

'Practitioners of osteopathy in the cranial field are jeopardising the profession'

Osteopathy is a relatively small health care modality in New Zealand with less than 400 practitioners across the country. Because of this small work force the actions of a few osteopaths could have a major impact on the rest of the profession. Focus Group A were worried about the negative impact that OCF practitioners were having on osteopathy's image as a whole. Sean, who had previously practiced in the United Kingdom, explained the difficulty facing the osteopathic profession, which has deeply affected his opinion of OCF:

We have gone through a hell of a thing to try and get regulated as a profession; in the UK particularly but here is not dissimilar. And to have earned our stripes and got one foot in the medical camp, one foot in the complementary camp, to be the kind of gatekeepers to complementary medicine as I see it, has been a hard fought battle. And I think we risk making a laughing stock of ourselves by having fruit loops going around squeezing heads and trying to claim great results from it. (p. 8-9, FGA)

This particular comment was not only directed at OCF but also craniosacral therapy. It appeared from the participants' discussion, that the practice of CST was having a negative impact on the osteopaths' opinions of OCF because of the similarity between the two modalities. This is likely to be related to CST being

more like the biodynamic version of OCF and, therefore, considered to be a more extreme form of practice. As mentioned previously, CST is an unregulated practice and its practitioners are not subject to the same regulation and monitoring as the osteopathic profession. This could be a concern for osteopaths as people often incorrectly interchange the terms OCF and CST. The possibility of confusion between the two modalities would constitute a threat to the image of osteopathy and also a threat to income.

Group N also expressed some concern that OCF practitioners were jeopardising the profession. Despite not having a negative opinion, Group N tended to agree that there were a small percentage of OCF practitioners who had an unfavourable impact on their opinions of OCF. Their opinion that OCF may be jeopardising the profession was largely due to actions and claims of a select few OCF practitioners that both Focus Group A and N believed were either practicing out of the scope of osteopathy or could be seen to damage osteopathy's reputation. Andrew believed some OCF practitioners' claims were bizarre. He used one of his personal experiences as an example:

There was an American professor whose specialty was cranial, and he was saying, "when you start to do cranial you treat the head, as you get better you will start to treat out further, you will be treating his environment, then you will treat with the whole room and when you are a total expert you will be treating to the horizon!" Imagine what I thought, I am sitting there going "give me a break!" (p. 22, FGA)

Although this may appear unusual, the concept of working with the environment to the reaches of the horizon can be found in biodynamic literature (Jealous, 2001; McPartland & Skinner, 2005).

Focus Group A believed that behaviour and concepts like these could put the credibility of the profession at risk. As outlined in Chapter Two it has only been since 2004 that osteopathy has gained statutory recognition in New Zealand; this in a sense legitimises the profession, thereby improving its image to the public

(Baer, 2009). If osteopathy lost its inclusion within the Act there might be significant economic consequences for many osteopaths. The threat of loss of income and security may be a significant driving force behind the OCF debate.

'Practitioners of osteopathy in the cranial field are great role models'

This next sub-theme demonstrates the shift from the negative 'they' to the positive 'they'. The majority of the participants from Group F found that the interactions they had had with OCF practitioners early in their careers positively influenced their opinions of OCF. The impressions that the OCF practitioners left on the participants fit the perception of what they themselves aspired to be as osteopaths. David had observed that there seemed to be a real positivity surrounding those who practiced OCF, which made him more inclined to try OCF as a modality. David says:

That is one of the things that drew me to it (OCF) as a student, you meet practitioners and you find out wow this person seems really interesting how do they treat? And just about without fail they were the people who enjoyed what they did for a job and got job satisfaction and were positive and welcoming to the profession. (p. 9, FGF)

David found the very opposite with structural practitioners saying that he found most structural practitioners he had met didn't really "enjoy life anymore" as an osteopath and he did not want to end up like that (p. 9, FGF). When David reflected further on this he said, "I would never have said starting my undergraduate programme that I would have been an OCF practitioner. I was very much, I'm going to crack that and get it to move!" (p. 4, FGF). That David was not initially inclined to practice OCF would further support the idea that his positive experience of OCF practitioners had a major impact on his current practice choices.

Positive experiences with very senior OCF practitioners whilst attending OCF courses in the United States had a major impact on key informant Jack also.

Whilst reflecting on this experience Jack said of the practitioners: *“All you could feel was love, respect, humility, and that really impressed me, and I wanted to be part of that. It was magical.”* (p. 10, KIF).

Interestingly, Jack was the only participant who had changed osteopathic schools during his studies from a more structurally based school to a more functionally based school. Jack was disappointed by what he found at this structurally based school saying, *“the people who practiced a more structural model of osteopathy had a very limited view of the practice of osteopathy and that wasn’t why I was there”* (p. 1, KIF). Therefore, for David and Jack a negative association with structural practitioners was perhaps as strong an influence as the positive experiences with OCF practitioners. Interestingly Jack’s change of school perhaps provides a glimpse that, for some people, intrinsic needs may be a stronger indicator of what modalities they will practice than which education provider they attend. With only one example of this in this research project, however, it is not possible to draw any firm conclusions.

The experiences of David and Jack demonstrate the positive dimension of ‘they’ and how the presence of role models that fit a practitioner’s belief system will profoundly influence their opinions of OCF.

Summary

This chapter has presented the findings of the study and described some of the influences that affect osteopaths’ opinions of OCF and their decision whether to incorporate OCF in their practice. Data were collected from three focus groups and two individual interviews with osteopaths who had a diverse range of practice experience, opinions and use of OCF.

Data analysis revealed three themes that influenced the participant’s opinions and practices in relation to osteopathy in the cranial field. These themes were: ‘me’ the intrinsic needs or beliefs of the osteopath, which related specifically to

the practitioner's requirements from their modality, 'it' the perception that osteopaths have of OCF as a modality and 'they' the impact that 'others' and at times their actions had on shaping the participants' opinions and practices.

Groups A and N had a greater diversity of driving influences behind their opinions and these tended to come under the theme 'it' and 'they'. Conversely Group F were more greatly influenced by the intrinsic factors which came under the theme 'me'.

In the next chapter the significance of the thematic influences 'me', 'it' and 'they' are discussed in relation to the role that the very meaning of osteopathy has on the debate. Despite the depth of the controversy of OCF, comparisons will be made to other healthcare professions including the chiropractic and medical profession to demonstrate the presence of such debates in other professions.

CHAPTER FIVE – DISCUSSION AND CONCLUSION

Introduction

In this chapter the key findings of the thematic analysis are reviewed followed by an in-depth discussion about these findings and the implications that these have for the osteopathic profession. The limitations of the study are also highlighted, and a proposal formulated for how research into this relatively under-explored area could best be directed in future studies. The chapter concludes with the final thoughts for the thesis.

Review of findings

The findings of this research determined that the participants' opinions of OCF and their decision whether or not to practice OCF were influenced by a variety of elements related to OCF. It became apparent that these influences could be considered within three thematic groups: identified as 'me', 'it', and 'they'. 'Me' included those influences that originated with the intrinsic needs or beliefs of the practitioners, 'it' referred to those influences that developed because of perceptions of the OCF modality itself, and 'they' incorporated the influences shaped by others and at times their actions. Overarching these themes was the influence imparted from the individual's perception of what is meant by 'osteopathy' itself, which demonstrated that the participants' opinions about OCF were formed because OCF did or did not match what they believed 'osteopathy' should be. The summative influence was therefore an interaction between the individual's understanding of the term 'osteopathic' and the

subsequent consequences this had on the intrinsic needs and beliefs of the individuals, and their perception of the OCF modality and osteopaths who practice OCF. It was this interaction, which over time, contributed to the formation of the opinions and practicing behaviours of the participants in relation to OCF.

What defines 'us' as a profession?

Once the predominant themes of the study were uncovered and presented under the three thematic groups, 'me', 'it' and 'they', it became evident that there was a significant lack of the concept of 'us'; 'osteopaths as a group' within the data. This is an important aspect of the OCF debate. It would appear that this lack of unity as a profession is a significant cause of the disagreement about OCF as a modality. The consequences of this in relation to the findings of this study are discussed in more detail in the following sections.

What is osteopathy?

During this research project there was some confusion about whether or not OCF was 'osteopathic' and it led to the question; what is it that defines osteopathic practice as 'osteopathic'? Although literature attempts to describe the term, it is arguably the individual's interpretation that gives the word 'osteopathic' its meaning. This is demonstrated by looking at the two very extreme opinions of OCF in this study. On one side are the practitioners who believe that OCF is not 'osteopathic', whilst on the other there are practitioners who believe OCF is 'osteopathic' by its very nature. This establishes that these practitioners not only disagree about whether OCF should be a modality within osteopathy, but they also disagree about what constitutes the very essence of osteopathy.

There is no universally agreed definition of what 'osteopathy' is, however, there are many explanations of what an osteopath does. A definition by A. T. Still is

used by the Osteopathic Council of New Zealand the regulatory authority for the osteopathic profession: “The work of the Osteopath is to adjust the body from the abnormal to the normal; then the abnormal condition gives place to the normal and health is the result of the normal condition.” (Osteopathic Council of New Zealand, n.d. What is osteopathic medicine?, para 6). This vague representation of what an osteopath does leaves much room for interpretation, and this explanation could be translated to fit many other healthcare practices.

As mentioned in Chapter Two the scope of osteopathy practice is also rather non-descript, and frustration with the scope of practice was evident throughout Focus Groups A and N. This frustration went much deeper than just OCF however. The practitioners from Group A in particular thought that the scope of practice was too expansive, allowing the practice of modalities that were somehow ‘unosteopathic’. Alternatively, it was mentioned during both Focus Group F and key interview F that it should not matter how an osteopath practices whether it be using manipulation, articulation or OCF; it is the principles and rationale guiding how the osteopath practices that really matter. This paradox highlights a considerable difference between the core beliefs of the two opposing groups and perhaps confusion about osteopathy’s identity. This indicates that there is a degree of misinterpretation of osteopathic principles at some point, but on which side of the debate this may be occurring is unclear. It would appear that there is a need for this to be investigated or at least discussed further. As key informant Jason suggested:

It is a debate we need to have I guess. We have been having it for years. It hasn't been a very sophisticated debate as you can see in the first scope of practice... the scope was really poorly worded... It means nothing you know. It is “osteopaths do what they are taught to do at accredited colleges” or something. (p. 11, KIA)

There are perhaps two ways in which this issue can be viewed. It could be argued that there is a step missing in this whole debate and that this relates to the core of what defines osteopathy; after all how can osteopaths decide whether OCF has

a place in osteopathic practice if they cannot even decide what osteopathy is? Alternatively maybe osteopaths should not have such finite definitions for osteopathic practice as this could encroach on their right as practitioners to choose their techniques.

The question surrounding what defines 'osteopathy' as a profession is a pressing issue as there are many reasons why the lack of identity could cause problems for the profession in the future. Of particular concern would be the lack of identity in relation to restructuring of the scope of practice and also standardisation of osteopathy as a profession, both of which are important aspects of being a registered profession. Certainly, the findings of this study have demonstrated that an osteopath's perceptions of what 'osteopathic' means play a major role in why they feel the way they do about OCF. In fact this could be the root cause of many of the preceding influences that affected the participants' opinions of OCF and thus a major contributor to the debate.

So, how do osteopaths form their perception of what 'osteopathic' means? Although it goes beyond the scope of this study I would argue that the educational institute that the individual attends would be significant in shaping the practitioners' interpretation of the term 'osteopathic'. Johnson and Kurtz's (2003) study investigating preferred osteopathic manipulative techniques would support this, saying that the education provider to which a practitioner is exposed will ultimately influence their technique choices when in practice.

One could assume that the teaching of osteopathic principles and practice is an important part of osteopathic curriculum. It is likely that different institutes, however, would place varying emphasis on these principles. Evidence suggests that there may be a lack of integration between the teaching of these osteopathic principles and the practice of osteopathy in a clinical setting in later stages of tuition (Johnson & Kurtz, 2001). Johnson and Kurtz (2001) suggest that by the time students begin practicing they may have largely forgotten the principles that underlie the osteopathic philosophy. This is also demonstrated in nursing practice where the gap that exists between theory and practice is well documented

(Olsen, 1998; Ousey & Gallagher, 2007). Like nursing there are most likely many factors that play a role in the lack of integration of osteopathic principles into practice, not just education.

Interestingly, similar to the osteopathic profession, the philosophical framework upon which the profession has been built and the relevance that this has today is also a pressing topic within the chiropractic profession (Meeker & Haldeman, 2002). This was demonstrated at a conference for the World Federation of Chiropractic in 2002, where discussions took place about the urgency of seeking resolution on the debate of chiropractic philosophy (Biggs, Mierau & Hay, 2002). The World Federation of Chiropractic was attempting to reach a “consensus on the core beliefs and basic tenets of the philosophy of chiropractic and how to teach them to students” (Biggs et al., 2002, p. 174). Current literature would suggest that this question still remains largely unanswered, illustrating the complexity of philosophical debate within healthcare modalities (Clum, 2007; Ebrall, Draper & Repka, 2008). This same dilemma that besets the chiropractic profession has significant implications for what is taught to osteopathic students. This is especially important when this study suggests that an osteopath’s core beliefs about the philosophy of osteopathy will play an important role in determining what modalities they will practice in the future.

I would suggest, that intrinsic factors would also influence an osteopath’s perception of what osteopathy means. The individual’s interpretation would therefore be that which satisfied the practitioner’s mind and reflected their internal value and belief systems. This reason may begin to explain why the same philosophy is used to support the two very different opinions in this study.

Certainly the participants’ understanding or interpretation of osteopathic philosophy and principles had a significant influence on why they chose to practice OCF or not. This may be related to both education provider and intrinsic factors.

The evolution of the osteopathic profession: where is the profession now?

With the meaning of osteopathy being questioned by participants within this study, it was not surprising that the underpinnings of the profession played an important role in the formation of the participants' opinions about OCF. When trying to define what osteopaths are now as a profession, a question is raised about where osteopaths must situate themselves in relation to the past and this includes their forbears. Although Still was the founder of osteopathy, it was Sutherland who was the founder of OCF. Interestingly it was Still who was frequently mentioned and not Sutherland throughout this study. It is possible that this is directly related to the importance the participants placed on the meaning of osteopathy in the development of their opinions about OCF.

Still the scientific man

In a 1998 study, which examined identity within the osteopathic profession, Miller discussed the importance that the founder plays in any profession, and suggested that the implication for osteopathy should be surrounding tradition and continuity rather than the content of Still's original philosophy. Still (1910) wrote "An osteopath must be a man of reason and prove his talk by his work. He has no use for theories unless they are demonstrated" (p. 6). It is impossible to know, if Still were alive, whether he would be interested in the evidence-based model that is practiced by many osteopaths today; indeed much of his work could be interpreted to match varying viewpoints, much like this excerpt. Because Still and his original concept of osteopathy played an important role in the development of the Group F participants' positive perception of OCF, one would assume that Still's historical reputation as a forward thinker and keen observer and investigator would be reason for research into the efficacy of OCF to be conducted. As Still (1910) said he would "accept nothing from a man unless he courts investigation and proves by demonstration that every statement is a truth" (p. 6). Conversely he also said man must "prove his talk by his work" (p. 6), which could signify that much like the participants from Group F, the positive clinical

outcomes that they achieve show sufficient evidence to justify the practice of OCF. Leach (2008) suggests that it is a combination of these ideas that would be of most benefit for the osteopathic profession:

Perhaps his [Still's] vision can help to lead us to a new vision for osteopathy as a discipline of the twenty-first century, can help us to avoid becoming either fossilized in blind adherence to tradition or technical slaves to scientific evidence. (p. 3)

The difficulty that Leach describes is a challenge that is once again not unique to osteopathy but one that is also faced by other similar health professions such as chiropractic (Meeker & Haldeman, 2002). This is important to osteopathy because of the parallels that can be drawn between the two professions. Like them osteopaths must use their history to inform present and future decisions combined with the emergent scientific evidence that is available today.

Still the spiritual man

Spirituality played a significant role in Still's life and references to a higher being can be found throughout his osteopathic writings, as is demonstrated in the following sentence: "God is the father of osteopathy, and I am not ashamed of the child of His mind." (Still, 1908, p. 254). This is an important statement when discussing the opinions of Group A that OCF was 'spiritual' and 'religious'. As mentioned in the introductory chapter of this study at the core of osteopathic philosophy is the understanding that the nature of man is 'triune' and that we are an inseparable unit of body, mind and spirit.

There were very different opinions about the importance of the concept of spirituality in osteopathy demonstrated in this study. It could be expected that the groups with very different opinions about OCF would also have very different opinions about the philosophies of osteopathy, such as the importance of the spiritual aspect of man. Surprisingly, within Group N there were also vastly differing opinions about the place that spirituality should have within osteopathy. Thus the influences that shaped the participants' opinions about

OCF were not always the same for all participants within the same group.

It would appear that some osteopaths are very comfortable with the relationship of spirituality to osteopathy, whilst others are not. One could argue that even though the concept of spirit can be found in many modern definitions of osteopathy it is a relatively underexplored area within the osteopathic classroom and therefore, despite being a fundamental philosophy of osteopathy is not always integrated into practice (Lee, 2005). This could explain why many osteopaths in this study found the 'spiritual' nature of OCF as endangering the credibility of the profession and it would also account for the differences in opinion within the same group.

On another note in relation to Still's philosophy and spirituality one member of Group A referred to the spiritual and religious nature of OCF as being a negative influence on his opinions but then went on to refer to Still's original philosophies as one of the reasons that OCF was not osteopathic. With Still's obvious spiritual inclination this demonstrates how poorly informed and contradictory the debate can be.

Like the debate about EBP, the debate about spirituality can also be seen in the chiropractic profession. An example of this is the concept of 'innate intelligence', which was advanced by Palmer the founder of chiropractic (Biggs et al., 2002; Kaptchuck & Eisenberg, 1998). This concept has been disputed since the founding of chiropractic in 1895 and is thought of by many to be nothing but "religious baggage" (Kaptchuk & Eisenberg, 1998, p. 2217). This is not dissimilar to what many OCF critics believe the "breath of life" or "primary respiratory mechanism" to be and this aversion to the spiritual elements of OCF was demonstrated throughout this study.

Metaphysical or scientific? - the lack of research

Juhl and Ostrow (2005) raise an interesting question in a letter to the editor of the Journal of the American Osteopathic Association: "Is osteopathy simply a metaphysical paradigm requiring faith or is it a scientific paradigm supported by

evidence?” (p. 127). This is a particularly relevant question to ask in relation to the findings of this study where on one side of the debate we have a lack of evidence driving negative opinions of OCF whilst on the other side practitioners use OCF where the only evidential support is belief and experience.

Group F were not concerned by a lack of evidence as they did not find it a necessary factor when determining how they will practice. This would support findings from a recent study that demonstrated that practitioners that leaned towards a more functional approach to treatment were less likely to be interested in EBP (Wittwer-Blaser, 2009). This disinterest in research contributed to Group A's belief that OCF practitioners were dogmatic and religious about OCF. Although there is perhaps more evidence supporting structural techniques, such as the use of manipulation for low back pain (Bronfort, Haas, Evans & Bouter, 2004), there are many other techniques that are yet to be supported by research. This again demonstrates how the argument against OCF is often poorly informed.

Contrastingly it has been suggested that OCF must work because of the anecdotal evidence that suggests its popularity. Just because a modality appears 'popular' however, does not necessarily mean that it is actually effective, and history is littered with examples of once common and popular medical therapies that are no longer in use. An example of this was the widespread use of bloodletting up until the late 19th century. Despite its popularity, bloodletting was generally ineffective and incredibly dangerous (DePalma, Hayes & Zacharski, 2007). Its ineffectivity combined with scientific advances eventually led to bloodletting falling into disrepute, although it is still used today in certain circumstances (DePalma et al., 2007). Conversely there are therapies that were once popular that have now proven effective, such as the use of leeches to restore blood flow to areas of the body. Today commonplace, mainstream medical practices continue to be questioned and updated as new information and research becomes available. This is illustrated in a recent article, which questions the use of breast screening for early cancer detection. Once thought of as a 'gold standard' for disease detection new research suggests screening often

leads to misdiagnosis, causing unnecessary physical and emotional trauma for many women (McPherson, 2010).

Osteopaths need not, therefore, be relying solely on the popularity of a modality such as OCF but perhaps questioning and developing the body of knowledge supporting these osteopathic practices. Juhl and Ostrow (2005) suggest that osteopaths should be comfortable with asking questions if they are to gain a deeper understanding of what it is to be an osteopath and they must inevitably ask whether those osteopathic techniques that have historically been practiced are still relevant today. Questioning should not be limited to OCF only but all osteopathic modalities and it is important that the very act of questioning be viewed positively as a process of healthy reflection rather than scrutiny.

Where to from here?

It is the very nature of academia to question what we do and therefore the kind of debate that modalities like OCF engender show that the profession is in its own way a self-regulating mechanism. Caution should be taken, however, as this debate can go beyond what could be considered to be 'healthy' debate, which in itself could damage the reputation of the profession in the eyes of the public and other healthcare professions. There will also always be practitioners who appear to practice outside of their scope of practice and this is not limited to OCF, or just to osteopathy. A regulatory authority exists to ensure that these select few do not damage the reputation of osteopathy. Although valid points were raised about some of the issues surrounding OCF, blaming the modality and all its practitioners for jeopardising the profession is arguably irrational.

A push towards the genesis of a greater body of evidence supporting osteopathic modalities would appear to be the natural progression this debate should take. Perhaps this body of evidence will provide greater understanding of all the techniques the profession currently uses. Group F were of the opinion that it was OCF that was carrying osteopathy forward in its development as a profession. There is no evidence to support this opinion, but because OCF is one of the

osteopathic modalities that is least understood it has great potential for research development.

Group F indicated that job satisfaction was a defining reason why they chose to practice OCF and that the OCF modality provided them with positive patient outcomes which is considered to be another factor in overall job satisfaction (Wolfe, 1981). That Kleinbaum (2009) found that osteopaths leave the profession due to a lack of job satisfaction would suggest that the positive aspects of OCF practice could be a beneficial way to maintain osteopathic practitioners within the profession.

It is futile not to accept that there will always be practitioners who practice OCF and there is much room for greater understanding and acceptance of different modalities within the osteopathic profession. Osteopathic practice is intrinsically linked to its philosophy, suggesting that it is osteopathic principles that should be the driving force behind any treatment; whether that be OCF or any other modality. With the state of regulation and current scrutiny of alternative and complementary therapies by public and media, it may be wise to be conducting research into the efficacy of osteopathic treatment methods. This does not mean that osteopaths should become ingrained in EBP but rather that the profession should embrace the ability of colleagues to conduct this research and find avenues to support what they do as a profession, as it is well within the reach of known science.

Implications and recommendations for the profession

This thesis has implications for osteopathic research, osteopathic associations and education providers.

Osteopathic research

Significant challenges to conducting credible research into osteopathy in the cranial field still exist. These include a lack of funding for research initiatives in the osteopathic profession and perhaps a lack of desire from those who practice OCF to conduct the research themselves (KIA). There has also been a significant amount of contention surrounding what research would be the most beneficial for the profession. In more recent years it has become apparent that research has been badly directed in the OCF field and things need to change if there is to be development of a greater base of knowledge about this controversial topic (Ferguson et al, 1998; Moran, 2005). An unexpected finding in this research was that even those who were seemingly against OCF would welcome more case studies and clinical outcome studies. The results from such studies could provide much needed information about the efficacy of OCF, and thus inform the debate through the creation of an updated body of understanding.

The focus group and individual interviews provided information about many topical issues facing the osteopathic profession. An example of this that has implications for osteopathic research was the following comment:

As a taxpayer do I want the money from my back pocket to be spent on things that are of dubious effect? And this is where the importance of research really comes home... if there was some good data showing effectiveness then I would be happy, but in the absence of that data or that the little bit of data that we do have isn't very favourable, I am really not so happy that my money gets spent on something that is unsubstantiated... I think we should be spending our health care dollars on things that clearly work. (p. 11, KIA)

Now that osteopathy is a registered profession and also funded by the Accident Compensation Corporation (ACC) the need for good quality osteopathic research appears vital. The public and regulatory bodies of today demand accountability from healthcare professions, and for osteopathy to maintain and develop its

standing it needs to evolve and keep up to date. Osteopaths cannot ignore the importance of maintaining credibility as a healthcare provider. There is a potential risk of losing the ACC provider position currently held, especially when ACC is currently experiencing financial pressure.

Osteopathic associations and education providers

This research has touched on the issue of the philosophical constructs on which osteopathy is based and the implications these have for the profession. Does the osteopathic profession need to articulate a new philosophy or as a profession are they comfortable with the current concept of osteopathy? There is little evidence indicating the nature and the extent of the divisions, and the sources of disagreement about osteopathic philosophy, which seems to play a significant role in much disagreement within the osteopathic community. Literature suggests that education providers are failing to integrate these philosophic principles into practice and this is something that perhaps education providers need to address (Johnson & Kurtz, 2001).

Limitations of the study

This study was a qualitative exploratory study into an under-researched field, based on the opinions and practices of a small sample of osteopaths in New Zealand and, therefore, cannot be generalised across the osteopathic profession. There is, however, potential for transferability of these results and osteopaths may identify with the influences demonstrated.

Because themes and patterns were not previously documented interpretive description was an appropriate method for the purpose of this study. Although a small sample is suitable when employing an interpretive descriptive method; the small sample size could be seen as a limitation of the study. Originally it was intended that six participants would be recruited for each focus group as this

number is widely considered to be an ideal number for focus groups (Krueger & Casey, 2000; Thorne, 2008). Unfortunately, due to the difficulty of recruiting participants this number was not reached and may have resulted in limitations to the data.

Alternatively the small number of participants in each focus group could be seen to be a strength as the more intimate size of the group may have made it easier for the participants to contribute freely to the discussion. The small focus groups meant that each participant had greater opportunity to comment on other participants' influences, which often prompted memories about further influences. This facilitation of open discussion is an important part of data collection using focus groups (Krueger & Casey, 2000). The key informants' contribution also helped to mitigate the small sample size.

In a survey of the osteopathic workforce in New Zealand, of 293 respondents (80 percent of the osteopathic population) 46 percent were female and 54 percent were male, this suggests that there is an almost even gender split in the osteopathic community in New Zealand (Ministry of Health, 2009). In this study there were 12 males and one female, therefore, this research does not address gender difference when looking at what influences osteopaths' opinions and practice of OCF. The cultural diversity of the participants was representative of New Zealand but was accidental and not something specifically considered when recruiting for this study.

Also, in relation to the method of this study if I were to repeat the group selection procedure again I would almost certainly alter the process; this demonstrates a limitation of the study. As the process progressed I realised that the groups should have been self selected rather than using the chosen set of screening questions (see Appendix B) as this caused some confusion amongst the participants who did not agree with the group that they were selected for. If this had not been noted prior to the focus group sessions it could have led to non homogeneous groups, rendering the data collection process extremely difficult, as participants within the groups would have had very different opinions about

OCF. Because the nature of the enquiry was an opinion study I believe participants should have been able to select the group that they felt they belonged to, as it was the participants' opinions that were being studied. Alternatively the set of screening questions could have been tested on a number of osteopaths prior to data collection to ensure suitability for group allocation. Although osteopathic practitioners were consulted about the wording and suitability of screening questions it would have been a more rigorous procedure to pilot them. Because of the nature of the study however, to the best of my knowledge this error of judgement did not interfere with the results of the study.

Another limitation of the study was that I was a novice researcher with no previous experience in conducting focus groups. Due to this lack of experience there were times when information offered by participants was not sufficiently explored. An example of this was in key interview F where the participant mentioned: *"I think that there is something deeper driving why I am doing this. In fact, I know there is something deeper driving why I am doing this."* (p. 12, KIF). I did not pick up on this during the interview although on reading the transcript I realised it may have been useful to explore this further.

As outlined throughout this study the topic of OCF within the osteopathic profession is very emotive and because I am an osteopathic student there could have been a conflict of interest. This could be seen to be a limitation of the study because qualitative research depends inescapably on the interpretation of the researcher (Thorne, 2008). As mentioned in Chapter Three, to limit the influence my personal perspective would have on the way I presented the findings of this study my 'positioning' on OCF was documented prior to data collection. This 'positioning' is presented for the reader in Chapter One where my personal interest in the topic is disclosed. This is aimed at limiting any unintended impact this may have on the credibility of this research. Having these thoughts documented also helped in the write up stage of the project as it allowed this 'positioning' to be managed and accounted for throughout the study. This proved invaluable when writing this discussion as it enhanced the process of reflection.

Finally, although all efforts were taken to provide a true and accurate representation of the information shared by the participants, because the study involved human experiential knowledge I think it is important to acknowledge the possibility of misinterpretation as a limitation of the study.

Future research

As identified in Chapter Two there was no research available at the time of this study examining what influences osteopaths' opinions about OCF and their subsequent decision whether or not to use OCF in their practices. There is a significant gap in research, which determines why osteopaths choose to practice the way they do. This has particular importance in relation to scope of practice and possibly education. Because there are such conflicting opinions about OCF within the osteopathic profession it is important to know more about why practitioners feel the way they do about OCF. More understanding on these topics could help inform the debate and ultimately improve understanding of the issue.

This study has provided insight into the influences that shaped the opinions of thirteen osteopaths, but the findings as mentioned previously cannot be generalised across the profession. A larger study would be very useful to see if this project had indeed achieved thematic saturation. A study with a greater number of female participants would also be of interest in determining if females are influenced by the same elements as males.

An important avenue of study would be to determine how many osteopaths in New Zealand would fit into each of the three groups from this project; strong opinions against OCF, neither strong opinions for nor against OCF and strong opinions for OCF. It would be useful to gauge the temperature of opinion about OCF for the broader osteopathic population. As highlighted throughout this research project this is increasingly important when it comes to proposals for the

scope of practice. Thus this type of quantitative study would be very useful for exploring this debate further.

Summary

This study uncovered many influences that had shaped both the participants' opinions of OCF and whether or not they chose to practice OCF. For the purposes of this study these were presented in three thematic groups: labelled 'me', 'it' and 'they'. 'Me' described those influences that were driven by intrinsic factors. 'It' detailed the influences shaped by the perception of OCF as a modality. And finally 'they' included those influences shaped by 'others' and at times their actions. Overarching these three thematic groups, was the influence that the individual's understanding of the term 'osteopathic' had on the participant's opinions. Analysis showed it was a dynamic interaction of these influences that determined whether or not an osteopath would choose to practice OCF.

The decision to present the findings of this study in this manner greatly influenced the discussion for this thesis, which was based on the largely absent theme of 'us', which unsurprisingly failed to have a strong presence in the data. There was significant disparity between all three groups and although participants had different opinions about OCF many of them used the same philosophy and principles to support their opinions of OCF. This in itself is a surprising finding as the participants were, in effect, using the same principles to support very different viewpoints. This would suggest that there is a lack of consensus or clarity about the very foundations of what constitutes osteopathy.

From this study I can only comment on the possible root cause of why there are very different understandings of the foundations of osteopathy as it goes beyond the scope of this study. It would appear that the different understandings of the foundations of osteopathy are due to a variety of factors including; differences in the way osteopathic principles are taught by various education providers,

difficulty integrating the principles into practice, intrinsic factors and of course the unique element of individual interpretation of the principles. Although these differences should be duly noted it is not unique to the osteopathic profession with similar dilemmas demonstrated both in nursing and chiropractic.

The relationship between the past and present also had a significant impact on the participants' opinions; the founder of osteopathy A. T. Still played a particularly important role. The past had significant implications when it came to research and EBP, spirituality and dogma and also raised a question about where osteopaths should situate themselves in relation to osteopathy's past. It would appear that a unique balance must be achieved that will combine the principles of old with new knowledge gained from research.

Like many other modalities osteopathy stands at a crossroads and is faced with the dilemma of defining their practice in the 21st century. As both a small and relatively young profession in New Zealand it is important that the osteopathic community presents a unified front on all issues. It seems inevitable that OCF will continue to be practiced despite fierce criticism from practitioners who would prefer to see OCF removed from the scope of practice. The chair of the Osteopathic Council of New Zealand perhaps agrees that modalities like OCF are here to stay saying; "It is a defect in logic to presume that there cannot be many forms of osteopathy, or worse, to seek to delegitimise forms of practice through the imposition of a restricted scope of practice statement (Osteopathic Council of New Zealand, 2010, Foreword, para 4). Whether scope of practice changes will affect the debate about OCF is unknown.

This study has highlighted considerations for the osteopathic profession as a whole. In particular it has implications for osteopathic research and for the teaching and development of osteopathic principles and practice by osteopathic associations and educational institutes.

The limitations of this research relate firstly to the method employed for this study. Because of the relatively small sample size the findings cannot be generalised across the profession but there is the possibility for transferability.

The sample used did not address gender difference, however, given the method used and the relatively under-explored nature of the phenomenon a small sample size was adequate. The group selection method was not entirely suitable for this study. My relative inexperience in conducting focus groups and interviews and my personal positioning on the research topic were also possible limitations of this study as was my interpretation of the data.

Further research is recommended into the debate surrounding OCF and the repercussions this has on the osteopathic profession as a whole. In particular it would be beneficial to determine how many osteopaths practice OCF in New Zealand so that this can be considered for any future changes to the osteopathic scope of practice.

Concluding thoughts

It became increasingly clear through completing this study that the debate about osteopathy in the cranial field is multifaceted. There are numerous reasons why practitioners feel the way they do about OCF, and these reasons themselves seem to have their own set of influences and motivations. As with most debates rational thought was intermingled with the emotional, thereby increasing the complexity of the issue. It would appear that due to the nature of opinion, this complex debate will in some way continue to persist, perhaps indefinitely. There is, however, a significant degree of positivity surrounding the findings of this research, which suggests that there are steps that can be taken to reduce the divide. As one of the participants suggested perhaps *“we need to focus less on what makes us different and more on what makes us the same”*.

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APPENDIX A – INFORMATION SHEETS



Focus Group Participant Information Form

An exploration of the factors that influence the opinions, behaviour, and motivations of those who do and do not practice osteopathy in the cranial field in New Zealand

You are invited to take part in a study undertaken within the Master of Osteopathy degree at Unitec New Zealand. The aim of this research is to begin to explore the factors that influence the opinions, behaviour, and motivations of those who do and do not practice osteopathy in the cranial field (OCF) in New Zealand. I hope to achieve this by:

- Identifying the influences that shape the opinions, attitudes, and use of OCF.
- Exploring the theoretical basis that informs practitioners' opinions and/or use of OCF.
- Identifying why osteopaths choose to use or not to use OCF.

I request your participation in the following way:

I would appreciate it if you could participate in a focus group to discuss your opinions, motivations and behaviours surrounding OCF and the factors that have may influenced these. A focus group is a group discussion coordinated by an interviewer, which is designed to obtain perceptions on a topic. These groups will be comprised of approximately 6 osteopaths who share similar opinions about OCF. The focus groups will be recorded and transcribed and a copy of the transcript from the focus group you participated in will be sent to you. You will be able to review, edit or withdraw any of your statements.

The focus groups will be held at the Unitec Mt Albert campus and will be approximately 60 minutes long but please allow up to 90 minutes.

If you think you may be interested in participating in this project, an indication of your opinion of OCF will be determined using a set of screening questions. These questions will not be aimed at testing your knowledge but rather how you feel about OCF. Three focus groups will be held and will include as follows:

1. People with strong opinions for OCF
2. People with neither strong opinions for nor against OCF
3. People with strong opinions against OCF

If you meet the criteria for one of these groups and you are able to attend the designated place, date, and time of that focus group you will be invited to participate in that group. If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project, however, due to the research schedule, any withdrawal of data must be done within 2 weeks of receiving the transcript.

These transcripts will be used in preparing a research thesis. This thesis may also be used for future purposes as part of a journal article and/or presenting findings at a conference or an osteopathic educational institute. Your name and any information that may identify you will be kept confidential and not used in the thesis or any articles or presentations. The only persons who will know what you have said will be the participants in your focus group, the researcher, and the researcher's supervisors. All information will be stored securely on a computer and in hard copy at Unitec for a minimum period of 5 years.

If you need more information or you have any concerns about this research project you can contact the researcher Joanna Braybrook phone 021 447 857 or email jobraybrook@hotmail.com or alternatively you may contact the research supervisor Dr Dianne Roy phone 815 4321 ext. 8307 or email droy@unitec.ac.nz

UREC REGISTRATION NUMBER: 2009-961

This study has been approved by the UNITEC Research Ethics Committee from the 27th of May 2009 to the 27th of May 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.



Individual Interview Participant Information Form

An exploration of the factors that influence the opinions, behaviour, and motivations of those who do and do not practice osteopathy in the cranial field in New Zealand

You are invited to take part in a study undertaken within the Master of Osteopathy degree at Unitec New Zealand. The aim of this research is to begin to explore the factors that influence the opinions, behaviour, and motivations of those who do and do not practice osteopathy in the cranial field in New Zealand. I hope to achieve this by:

- Identifying the influences that shape the opinions, attitudes, and use of OCF.
- Exploring the theoretical basis that informs practitioners' opinions and/or use of OCF.
- Identifying why osteopaths choose to use or not to use OCF.

I request your participation in the following way:

I have identified you as someone who may be able to provide more information on the topic of this thesis. I would appreciate it if you could participate in an individual interview to discuss your opinions, motivations and behaviours surrounding OCF and the factors that may have influenced these. The interview will be recorded and transcribed and a copy of the transcript will be sent to you. You will be able to review, edit or withdraw any or all of your statements.

The interview will be held at a venue suitable for you and will be approximately 60 minutes long but please allow up to 90 minutes. If you agree to participate, you will be asked to sign a consent form. This does not stop you from changing your mind if you wish to withdraw from the project, however, due to the research schedule, any withdrawal of data must be done within 2 weeks of receiving the transcript.

The transcript will be used in preparing a research thesis. This thesis may also be used for future purposes as part of a journal article and/or presenting findings at a conference or an osteopathic educational institute. Your name and any information that may identify you will be kept confidential and not used in the

thesis or any articles or presentations. The only persons who will know what you have said will be the researcher and the researcher's supervisors. All information will be stored securely on a computer and in hard copy at Unitec for a minimum period of 5 years.

If you need more information or you have any concerns about this research project you can contact the researcher Joanna Braybrook phone 021 447 857 or email jobraybrook@hotmail.com or alternatively you may contact the research supervisor Dr Dianne Roy phone 815 4321 ext. 8307 or email droy@unitec.ac.nz

UREC REGISTRATION NUMBER: 2009-961

This study has been approved by the UNITEC Research Ethics Committee from May 2009 to May 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (ph: 09 815-4321 ext 6162). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

APPENDIX B – SET OF SCREENING QUESTIONS

Part One

a. Osteopathy in the cranial field is the future of osteopathy.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 4 | 3 | 2 | 1 | 0 |

b. I have strong opinions against osteopathy in the cranial field.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 0 | 1 | 2 | 3 | 4 |

c. Osteopathy in the cranial field should be part of most diagnostic and treatment regimes.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 4 | 3 | 2 | 1 | 0 |

d. Osteopathy in the cranial field should not be practiced because it totally contradicts the findings of physics, anatomy, physiology, and biomechanics.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 0 | 1 | 2 | 3 | 4 |

e. I strongly support the use of osteopathy in the cranial field.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 4 | 3 | 2 | 1 | 0 |

f. I would never use osteopathy in the cranial field because I refuse to believe it is a reliable and useful treatment model.

| | | | | |
|----------------|-------|----------------------------|----------|-------------------|
| Strongly Agree | Agree | Neither Agree nor Disagree | Disagree | Strongly Disagree |
| 0 | 1 | 2 | 3 | 4 |

Part Two

1. Briefly what do you think of osteopathy in the cranial field?
2. How often would you use osteopathy in the cranial field? (I.e. every patient, most patients etc.)
3. Please circle the group you feel you best identify with.
 - A) Strong opinions against osteopathy in the cranial field
 - N) Neither strong opinions for nor against osteopathy in the cranial field
 - F) Strong opinions for osteopathy in the cranial field

APPENDIX C – CONSENT FORM



Thank you for agreeing to participate in this research project being undertaken for the Master of Osteopathy programme at Unitec New Zealand.

Consent Form

An exploration of the factors that influence the opinions, behaviour, and motivations of those who do and do not practice osteopathy in the cranial field in New Zealand

Name _____ of
Participant: _____

I have had the research project explained to me and I have read and I understand the information sheet given to me.

I understand that I do not have to be part of this if I do not want to and I may withdraw from the focus group or individual interview at any time. I may withdraw or edit any or all of my contribution to the discussion made during the focus group or individual interview within two weeks of receiving the transcript.

I understand that everything I say is confidential and none of the information I give will be used in a way that identifies me. I understand that the only persons who will know what I have said will be the participants in the focus group I took part in, the researcher, and the researcher's supervisors. I also understand that all the information that I give will be stored securely on a computer and in hard copy for a minimum period of 5 years.

I understand that my discussion within the focus group or individual interview will be recorded and transcribed by the researcher.

I understand that I will receive a copy of the transcript and I can see the finished research document.

I have had time to consider everything and I give my consent to be a participant in this study.

Participant Signature: Date:

Project Researcher: Date:

UREC REGISTRATION NUMBER: 2009-961

This study has been approved by the Unitec Research Ethics Committee from the 27th of May 2009 to the 27th of May 2010. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Committee through the UREC Secretary (Ph: 09 815 4321 ext.7254). Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

APPENDIX D – GENERAL FOCUS GROUP AND INDIVIDUAL INTERVIEW QUESTIONING ROUTE

Focus Group and Individual Interview A - Strong opinions against osteopathy in the cranial field (OCF)

- Participant introductions and discussion of group processes including confidentiality.
- What is your opinion of OCF? (Introductory Question)
- What do you believe to be the most profound influences on your opinions of OCF and why you choose not to practice OCF? (Key Question 1)
- Do you think that OCF should be removed from the osteopathic scope of practice and why? (Key Question 2)
- How has your osteopathic education influenced your opinions of OCF? (Key Question 3)
- How do you feel your colleagues view OCF? Does this affect your opinion of OCF? (Key Question 4)
- How does evidence based practice influence your opinions of OCF (Key Question 5)
- What are your impressions of this focus group and is there any additional information you would like to add. (Closing Question)

Focus Group N - Neither strong opinions for nor against osteopathy in the cranial field (OCF)

- Participant introductions and discussion of group processes including confidentiality.
- What is your opinion of OCF? (Introductory Question)
- What do you believe to be the most profound influences on your opinions of OCF? (Key Question One)
- How has your osteopathic education influenced your opinions of OCF? (Key Question Two)

- How do you feel your colleagues view OCF and does this affect your opinion of OCF? (Key Question Three)
- Do your patients' opinions of OCF influence your use OCF? (Key Question Four)
- How does evidence based practice influence your opinions of OCF? (Key Question Five)
- What are your impressions of this focus group and is there any additional information you would like to add. (Closing Question)

Focus Group and Individual Interview F - Strong opinions for osteopathy in the cranial field (OCF)

- Participant introductions and discussion of group processes including confidentiality.
- What is your opinion of OCF? (Introductory Question)
- What do you believe to be the most profound influences on your opinions of OCF and why you choose to practice OCF? (Key Question One)
- How has your osteopathic education influenced your opinions of OCF? (Key Question Two)
- How do you feel your colleagues view OCF and does this affect your opinion of OCF? (Key Question Three)
- Do your patients' opinions of OCF influence your use of OCF? (Key Question Four)
- How does evidence based practice influence your opinions of OCF? (Key Question Five)
- What are your impressions of this focus group and is there any additional information you would like to add. (Closing Question)