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The Scope of Osteopathic Practice in Europe

Working Group on Scope of Practice

European Federation of Osteopaths (EFO)
Forum for Osteopathic Regulation in Europe (FORE)

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Foreword and acknowledgements

September 2009, during a meeting between the EFO board and a delegation of FORE in Brussels, a committee was formed to write a Scope of Osteopathic Practice in Europe (SOPE). The initiative for SOPE came from the EFO board. Representatives coming from organizations from England, France, Italy, Belgium, Finland, Spain, Sweden, Ireland and the Netherlands took a seat in the SOPE committee (see appendix V). The EFO board also had a representative in the group.

EFO and FORE are both European organizations working for osteopathy and its osteopaths. EFO members are Associations for osteopathy from different European countries. EFO hosts a European register for osteopaths that are registered in their home country with a registry that meets minimum standards used by the EFO.

FORE is a forum for regulators. Representatives from European osteopathic associations and registers are invited to meet in order to work on consensus about the profession and work on minimum standards for the professionals.

Both EFO and FORE produced “frameworks” and “codes”. These documents were taken into account when writing the Scope (Bibliography).

The organizations investigate a merger. SOPE will be the first document produced in cooperation by the two organizations and their representatives.

The SOPE-group came together in Stockholm, London, Amsterdam (2 times), Milano and Paris. Much of the work is done by e-mail.

The Scope is written to inform the osteopaths throughout Europe, governments, the public, the schools, other healthcare practitioners, insurance companies, etc. about osteopathy and to inform about what can be expected in osteopathic practice.

SOPE will contribute to more transparency.

Many thanks, on behalf of the SOPE-group, go to the Board of the EFO for their confidence in our work.

Even more thanks, on my behalf, go to the members of the group for their dedication and expertise. Not everyone had the same level of input, but all were supportive and worked with integrity.

We want to thank our colleagues throughout Europe for taking the time to read this document and assess. I look forward to the feedback coming to us via your organizations. We tried to achieve an academic level by underpinning the words we wrote down. Please, if you have any lines for us could you provide us also the underlying references.

Ton Kouwenberg, chair of the committee

Introduction to the document

For many people it is not clear what is happening in the osteopathic practice and how the osteopath thinks and works. We hope this document will help to clarify this and show the seriousness of the osteopathic profession.

We tried to be as inclusive as possible without writing a huge document. In appendices you can find additions to the text.

Osteopathy in Europe is at a different level of development in the European member states. Data about osteopathy in Europe can be found in appendix VI.

Both EFO and FORE worked on consensus. As stated before the organizations investigate a merger. SOPE is the result of a good collaboration.

You will find a chapter about the history of osteopathy in Europe. The route from the US to the UK and further to the European continent is looked at.

Defining osteopathy has been tried by so many wise people. In a detailed definition it is difficult to include everything. We will give a short, general definition and you will find more definitions from other organisations in appendix I.

The chapter about the concepts, principles and characteristics of osteopathy is a very important one. Together with the chapter about osteopathic practice osteopathy in Europe will be much more transparent.

We looked at references for effectiveness of osteopathic treatment and mention them in appendix III.

Osteopathy deserves a position in the healthcare system. In chapter 4 we explore this topic.

Chapter 8 is about next steps. While we worked on the document we came up with topics for a sequel. We put this as suggestions in the last chapter.

1 History of Osteopathy

2 Definition of Osteopathy¹

Osteopathic medicine is a primary contact healthcare profession which diagnoses and treats dysfunctions in the mobility of bodily tissues which affect the state of health.

Osteopathic medicine promotes health, and aids recovery from and prevention of recurring symptoms, through its non-surgical, drug free treatment (Milan, Jan 2010).

3 Concepts, Principles and Characteristics of Osteopathy

3.1 The Concepts and Principles of Osteopathy

The practice of osteopathy uses current medical and scientific knowledge to apply the principles of osteopathy to patient care. Scientific plausibility and evidence-based outcomes have a high priority in patient treatment and case management.

Osteopathy provides a broad range of approaches to the maintenance of health and the management of disease. It embraces the concept of the unity of the individual's structure (anatomy) and function (physiology); as such osteopathy is a patient centered system of health care, rather than disease centered.

¹ Still more definitions are listed in appendix I

Osteopathy emphasizes the following principles:

- The body possesses self-regulatory mechanisms that are self-healing in nature.
- Structure and function are interrelated across and at all levels.
- The human being is a dynamic unit of function, whose state of health is influenced by the body and mind.
- Rational treatment is based on these principles.

An essential component of osteopathic medicine is structural diagnosis and osteopathic manual treatment. Osteopathic treatment was developed as a means to facilitate normal self-regulating/self-healing mechanisms in the body by addressing areas of tissue strain, stress or dysfunction which may impede normal neural, vascular and biochemical mechanisms.

The practical application of the concepts and principles are described by several models of structure-function relationships that osteopathic clinicians use to influence the gathering of diagnostic information and the interpretation of the significance of neuromusculoskeletal findings in the overall health of the patient.

As such it is not limited to the diagnosis and treatment of musculoskeletal problems, nor does osteopathy emphasize joint alignment and radiographic evidence of structural relationships. Rather, osteopathy is more concerned with the manner in which the biomechanics of the musculoskeletal system are integrated with and support the entire body physiology. Osteopathy acknowledges that each human body is constructed of the same components and their corresponding functions, but is also aware that each individual develops their own biomechanical adjustments as a response to any physical, chemical, emotional and psychological events that might be of influence.

Typically a combination of models will be appropriate for an individual patient. The combination chosen is modified by the patient's differential diagnosis, co-morbidities, and other therapeutic regimens.

The following five models of structure-function guide the osteopathic clinician's diagnosis and treatment of the patient. The models describe the effects of postural and biomechanical factors on the patient's ability to compensate for stressors or illness; the influence of the nervous system on physical, cognitive, and emotional health; the importance of the respiratory-circulatory system in maintaining proper cell and tissue function; the role of psychosocial factors in preventing and treating disease; and factors which influence bioenergetic needs such as oxygen and nutrient consumption.

These models² are:

- *Biomechanical Model:* This model views the body as an integration of somatic components that relate as a posture and balance mechanism. Stresses or imbalances within this mechanism will affect dynamic function and result in increased energy expenditure, altered proprioception³, changes in joint structure, impediments of neurovascular function and altered metabolism. Osteopathic

² References to underpin these models are listed in appendix II

³ Proprioception is the sense of the relative position of neighbouring parts of the body.

treatment within this model allows for restoration of posture and balance, and efficient use of the musculoskeletal components.

- *Neurological Model:* The neurological model considers the effects of spinal facilitation, proprioceptive function, balance between the components of the autonomic nervous system, and activity of nociceptors (pain fibres) on the function of the neuroendocrine immune network. Of particular importance is the interrelation of the musculoskeletal and visceral systems through the autonomic nervous system. Osteopathic treatment within this model focuses on the reduction of mechanical stresses, balance of neural inputs and the elimination of nociceptive drive.
- *Respiratory/Circulatory Model:* This model concerns itself with the maintenance of extra- and intracellular environments through the unimpeded delivery of oxygen and nutrients and the removal of cellular waste products. Any tissue stress interfering with the flow or circulation of any bodily fluid can affect tissue health. Osteopathic treatment within this model would address dysfunction in respiratory mechanics, circulation and the flow of bodily fluids.
- *Bio-psychosocial Model:* This model looks at the various reactions and psychological stresses with which patients contend. Health may be affected by environmental, socio-economic, cultural, physiological and psychological factors. Somatic dysfunction⁴ in the musculoskeletal system may be a reaction to environmental, socio-economic, cultural or psychological conditions, but can in turn, reinforce physiological stress.
- *Bio-energetic Model:* The body seeks to maintain a balance between energy production, distribution, and expenditure. This aids in its ability to adapt to various stressors: immunological, nutritional, psychological, etc. Osteopathic treatment within this model would address somatic dysfunction, which has the potential to deregulate the production, distribution or expenditure of energy.

It is of course imperative for thorough knowledge of the physiological mechanisms of these models to be taught extensively in an osteopathic curriculum.

3.2 The characteristic features of osteopathy

Even though the aforementioned principles can no longer be seen as exclusive to osteopathy, they are still part of its conceptual framework and a distinction might be found in the level of interweaving and depth with which they are applied in everyday practice.

Although manual techniques are used by many types of clinicians, such as chiropractors, physiotherapists, etc., the unique manner in which osteopathic manipulative techniques are integrated into patient management, as well as the duration, frequency and the choice of technique are all distinctive aspects of osteopathy. Osteopathy is not limited to the spinal thrust techniques often associated with manual medicine. Many forms of osteopathic

⁴ Somatic dysfunction: impaired or altered function of related components of the somatic (body framework) system; skeletal, arthrodial and myofascial structures and their related vascular, lymphatic and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

manual techniques are taught and used by osteopaths. These include thrust or impulse techniques as well as very gentle techniques (see chapter 5).

Despite the fact that the different forms of manual medicine each have their own technical arsenal and method of application, continuous progress in interprofessional exchanges has naturally meant that in the search for an efficient manual therapeutic approach, those techniques are selected that are considered most appropriate. Over time, this technical Darwinism has resulted in a considerable transfer of techniques from one profession to another. Against the backdrop of this transmission of techniques, it is crucially important to remember that the arsenal of applied osteopathic techniques does not define osteopathy itself. They are only part of the practice of osteopathic medicine. The underlying concept, the underlying osteopathic process of thinking and how these are implemented in practice are what distinguish osteopathic medicine from other manual forms of medicine, much more so than its techniques and how they are performed.

Although the range of techniques, as indicated above, is not one of the characteristic features of osteopathy in comparison to the arsenals of the other forms of manual medicine, within the profession we do refer to the “osteopathic touch”⁵ (see also chapter 5.3). This is a concept that is quite separate from the practical manual techniques and that is believed to be specific to our occupational group.

Other characteristics, such as the holistic⁶ nature of osteopathy and the adherence to the salutogenetic⁷ and/or hygiogenetic⁸ model, are not exclusive to osteopathy and can also be brought back to the principle of unity and the potential for self-regulation respectively.

Another important concept within osteopathy is that of “function”⁹. Functions are at all levels contextual and relational, from local function of a body part to the function of a

⁵ We would define the ‘osteopathic touch’ so often referred to in osteopathic literature as a highly developed haptic ability coupled with competent technical skill.

⁶ The word “holistic” is used here to convey the concept first mooted at the start of the last century within the field of biology as an alternative to the notion that life can be explained by means of purely mechanistic principles, on the one hand, and the idea that to explain life we must assume a life force, on the other hand. The holistic perspective understands all things in terms of an organic whole and not as separate physical and chemical elements, as prescribed by mechanistic thinking. The theory of a characteristic life force, such as is present in vitalism, is thus rendered superfluous and indeed must be considered unscientific. Essentially, holism views the organism as more than just a mechanical aggregate: rather it is a true and unified **whole**, hierarchically organised and displaying various levels of complexity. At each level the whole is more than merely the sum of the parts. The behaviour of each level is determined by principles that cannot simply be reduced to the laws which govern its components. Study of the lower levels is necessary, but not sufficient in order to understand the upper levels. “New”, “**emerging**” characteristics are to be found, or rather “reveal themselves” at each new level of complexity.

Living organisms strive towards the realization and preservation of the normality of this whole. Anomalies are counterbalanced wherever possible, as is evident during embryogenesis and physiological homeostasis (Willemsen H. (ed.), *Dictionary of Philosophy, entry on The Vitalism vs. Mechanism Debate*, Assen, Van Gorcum, 1992, p. 457-461)

⁷ ‘Salutogenesis’, as defined by Israeli sociologist Aaron Antonovsky, can be seen as a counterpart of ‘pathogenesis’. The term describes an approach focusing on factors that support human health and well-being, rather than on factors that cause disease. More specifically, the “salutogenic model” is concerned with the relationship between health, stress and coping.

⁸ Hartmut Heine suggested the alternative term ‘hygiogenesis’ as a counterpart to pathogenesis, defining it as the activation of self-healing forces.

⁹ Tyreman S.J., *The Concept of Function in Osteopathy and Conventional Medicine: A Comparative Study*, 2001, PhD Project, BSO, London

person in their physical and social environment. Clinical decisions depend on how this context is formed and understood.

Osteopathy adopts a specific approach to the contextual and relational character of function. On the one hand osteopathic evaluation and diagnosis stress the importance of the whole in reaching a better understanding of the parts. On the other hand dysfunctional local systems are identified in a quite specific way.

A study of the literature¹⁰ shows us that the traits mentioned above are no longer the preserve of osteopathy, but that the combination and particularly the practical implementation thereof most certainly do define its identity.

To summarise: Current osteopathic practice has left behind the metaphysical doctrines of its founder. What remains is a unique clinical practice restricted essentially to the use of manual techniques to achieve a diagnostic or therapeutic goal. The majority of osteopathic indications are to be found in the sphere of functional pain of the locomotor apparatus. The aim of osteopathic treatment – and perhaps this is the one thing that does remain of Still's teachings – is to return the organism to normal function and therefore restrict the need for medication or surgery. It is possible that other motives for consulting an osteopath, linked to other functions such as the digestive system or circulation, will eventually reach the same level of scientific grounding thanks to further clinical and basic research and will therefore be elevated to the status of fully fledged indications for osteopathic treatment¹¹. Such research will have to be conducted in the environment of a university and cooperation with other medical specialisations will be vital.

Osteopaths are active in first-line medical care, both for diagnosis and therapy; they act as mediators in the maintenance and/or restoration of health, working closely together with the patient and mainly through touch; to this they add a manual technique that is aimed at restoring lost function, at all levels of the body.

4 The position of osteopathy within public healthcare

Today, the field of operation of the professional osteopath is situated within first-line medical care. Indeed, as a profession, osteopaths have laid claim to this role.

Patients do not require to be referred from a general practitioner or specialist in order to make an appointment with an osteopath. Whenever possible, osteopaths will work alongside GPs, specialists and/or other healthcare disciplines, to the extent that this meets with the consent of the patient.

The osteopathic profession remains independent in terms of the actions (expertise, diagnostics, safety, care), attitude (respect, handling of information, relation of trust and awareness of responsibility) and work organisation (efficiency, protection, right to complain) of the osteopath.

¹⁰ Wagner C., Exploring a European osteopathic identity: analysis of professional profiles of European osteopathic organizations, 2009, WSO-DUK, master thesis, Vienna.

¹¹ We refer you at this juncture to the recently published NICE Guidelines (National Institute for Health and Clinical Excellence): Early management of persistent non-specific low back pain, 2009.

To which field of operations within first-line medical care does osteopathy belong?

Osteopathy can be both complementary to, as well as an alternative to more standard medical treatment. Alongside its curative function, osteopathy also has, by virtue of its conceptual background, a place within preventive medicine.

Osteopathy is used to treat both musculoskeletal and non-musculoskeletal conditions and dysfunctions. As such it has a clear role within curative and preventive medicine.

Osteopathic medicine is concerned less with conditions and diseases than that which has compromised the health, so it is not very informative to present a list of conditions which osteopathic treatment may help. Consequently, the following is offered only as a general guide to the varied range of presenting complaints that patients might bring to their osteopath. It is not exhaustive:

- Problems relating to the mechanical and nervous systems, such as pain, discomfort and impaired function of muscles and joints and their associated structures.
- Falls, injuries and strains, the effects of poor posture, tension, emotional stress and headache.
- Impaired function of body systems presented as digestive problems, circulatory disturbances, respiratory conditions, ear, nose or throat problems especially in the young, stress-related conditions and infective diseases. Osteopathic care has also been shown to assist effectively in in-patient care and post-operative convalescence.
- Sports-related problems at all levels, including elite athletes.
- Problems associated with pregnancy, expectant mothers, the newborn and childhood.
- Sometimes patients do not know what is wrong, but they do not feel well. They perhaps do not feel themselves or are not as comfortable as they should be.

Recent studies have shown osteopathy to be effective in a series of conditions and diseases. Some studies suggest that osteopathic care is cost-efficient, may decrease patient need for drug treatment; may expose the patient to less diagnostic testing and that the risk of complications is in most cases lower¹².

Beside its curative role, osteopathy also claims to have a preventive function within healthcare. The aims of preventive medicine are to promote and maintain good health, prevent disease, counter the progression of disease and prevent chronic illness.

The preventive function of osteopathy is determined by the osteopathic vision of disease and health as gradual phenomena where the patient's dysfunction is believed to be prodromal¹³ to pathology. The essence of this osteopathic vision of disease and health is that the organism carries within itself the potential for health. This vision leads to a form of prevention that differs from what society today understands prevention to mean.

Generally speaking, osteopaths are self-employed and run their own practice, sometimes together with other practitioners. Osteopaths can also be employed by hospitals and any other kind of care facility.

Osteopaths do not claim full authorisation to all areas of health and disease, however, they

¹² A non exhaustive list of studies can be found in appendix III

¹³ Prodromal is an early symptom (or set of symptoms) that might indicate the start of a disease before specific symptoms occur.

do work across the entire spectrum of health and disease, together with other healthcare professionals, i.e. osteopaths do not limit themselves to a certain area of healthcare. Osteopaths practise their profession with complete independence. They work diagnostically as well as therapeutically. They are first-line practitioners with a high degree of responsibility: their specialist training in neurology and locomotor pathology, as well as in general semiology, enables them to identify those pathologies that can(not) be treated directly using their skills. They are aware of the possibilities but also the limitations of their profession and act consequentially.

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5 Osteopathic Practice

5.1 Osteopathic consultation

An osteopathic consultation consists of the osteopath taking and recording a present and past case history and conducting appropriate osteopathic and clinical examinations to assist in the assessment of the patient.

The osteopath formulates a diagnosis and prognosis, communicates these effectively to patients and therefore plans an osteopathic treatment dealing appropriately with clinical findings, performs the treatment and reassesses the results of this.

5.2 Case history

The osteopath takes a comprehensive past and current medical history from the patient, including family history and details of the presenting problem. This allows the patient to express their version of events and thoughts, with occasional prompting to focus on and elicit further detail for important areas. A range of relevant questions is asked, including reference to third party reports and findings from the patients, to identify red¹⁴ and yellow flags¹⁵ to assist in formulating an exclusion diagnosis, a differential diagnosis and a working diagnosis. Significant attention is given to predisposing and maintaining factors that may have led to the problem, such as occupational, recreational or stress.

The osteopath will maintain a comprehensive written record of the consultation and subsequent contact with the patient. This information will be treated as strictly confidential.

At this stage the osteopath will satisfy his/herself that it is safe to continue with observation and examination

5.3 Observation and clinical examination¹⁶

Based on the case history, a range of possible diagnoses is generated. A relevant and detailed osteopathic clinical examination, tailored to the individual patient and his or her problem, is performed in order to explore these.

When necessary, the osteopath will use the clinical examination procedures that are familiar to most people and widely used by healthcare practitioners, in order to examine all body systems. In addition, however the osteopath will use specific osteopathic examination techniques such as observation and palpation to evaluate the quality, state, mobility and health of the mechanics of the joints, muscles and the other tissues of the body. This will lead to an initial working diagnosis of what the osteopath considers might explain the patient's problem. The osteopath will then determine the most relevant options for dealing with this and communicate these to the patient.

¹⁴ Greenhalgh S. Red flags: a guide to identifying serious pathology of the spine. Greenhalgh S, Selfe J, editors. Philadelphia: Elsevier; 2006.

Sizer PS, Brismée JM, Cook C. Medical Screening for Red Flags in the Diagnosis and Management of Musculoskeletal Spine Pain. *Pain Practice* 2007;7(1):53-71.

¹⁵ Kendall N.A.S., Linton S.J., Main C., Psychosocial Yellow Flags for acute low back pain: 'Yellow Flags' as an analogue to 'Red Flags', *European Journal of Pain*, 1998, 2: 87-89

N.A.S. KENDALL, S.J. LINTON AND C. MAIN Newton-John T., Ashmore J., McDowell M. Early intervention in acute back pain: Problems with flying the Yellow Flag, 2001, *Physiotherapy*, 87, 8, 397-401

Sowden M., Hatch A., Gray S.E., Coombs J., Can four key psychosocial risk factors for chronic pain and disability (Yellow Flags) be modified by a pain management programme? A pilot study, *Physiotherapy* 92 (2006) 43-49

¹⁶ Most common used diagnostics tools used by osteopaths and an Assessment of a somatic dysfunction are listed in appendix IV

Diagnosis could be viewed as collecting a set of findings from the history and examination and using these just to identify the name of a disease, condition or syndrome. This is useful in communicating predetermined pathology, signs and symptoms. The osteopath, however, strives to achieve a much more comprehensive understanding and explanation of the various factors involved, rather than simply providing a convenient label. Further, the osteopathic interpretation of a patient's problem may evolve as the treatment progresses and a greater understanding of the condition unfolds.

Palpation

Palpation is the highly trained and practised sense of touch, a hallmark of the osteopath. It is known that we obtain information about the world through our five senses: sight, sound, touch, taste and smell. It is also known also that we can train these senses, as we do with the sense of sight when we learn to read; that a tea or wine taster trains the sense of taste; a perfumer trains the sense of smell; a musician trains the ear. In the same way, from the outset of their training, osteopaths develop their sense of touch, to be able to feel information that is not readily experienced by the untrained hand. These all are primary senses, which cannot be described, only compared with itself or another sense.

At this point the osteopath has sufficient findings to identify red or yellow flags and so proceed to treatment or not.

5.4 Evaluation, treatment and management

The osteopaths synthesize their findings from the observation and examination to confirm or review their working diagnosis. The osteopath then correlates and prioritizes the somatic dysfunction(s) of all the patient's bodily systems and designs a treatment plan accordingly.

At this stage the osteopath discusses the diagnosis and treatment plan in detail with the patient. Finally he formulates a prognosis for the patient.

5.5 Treatment

Osteopathic treatment addresses the mobility of the patient's bodily tissues, which affects their overall state of health. Osteopathy offers a range of manual techniques which can be categorized as direct, indirect, combined, fluid and reflex based.¹⁷

- Direct techniques may be applied specifically to a joint or non-specifically to a body area. Direct techniques engage the restrictive barrier and use an activating force to correct the somatic dysfunction. Direct techniques may use thrust, impulse, muscle contraction, fascial loading, or passive range of motion to achieve the tissue response.
- Indirect, fluid, balancing, or reflex based techniques may be applied specifically to a joint or non-specifically to a body area. These techniques do not engage the restrictive barrier. These techniques may use fascial massage, fascial and soft-tissue loading or unloading, hydraulic pressures, phases of respiration, cranial or postural adjustments as part of the application of the technique.

¹⁷ Further details of manual treatment acts are listed in appendix IV

Manipulative techniques are used to influence patient's health in accordance with the aforementioned models (chapter 3.1).

These techniques can apply to varying levels of the body, for example, specific soft tissue techniques for muscles and ligaments; specific joint mobilization or positioning to improve the range and quality of their motion; rapid controlled thrusts to joints; manual techniques to restore function to visceral structures; etc.

The choice of treatment techniques or modalities, are influenced by many factors such as:

- Patient's presenting complaint
- The illness
- Age
- General well-being
- General health
- Previous medical history
- Osteopathic examination findings
- Drug use
- ...

At this stage the treatment plan and subsequent choice of techniques are specific to the patient.

The scope of treatment extends to empowering the patient to maintain their health through education and general lifestyle advice.

It is important that the patient is continually updated and informed in a clear manner of the diagnosis treatment protocol, treatment strategies or alternative treatment modalities which may be recommended. The patient is informed of potential risks, side effects and the timeframe for treatment. The patient must give consent before commencing any treatment.

5.6 Ongoing case management

At the start of each consultation the patient is asked to report any progress or change relating to their complaint. The osteopath then carries out a new examination and commences further treatment accordingly. The initial diagnosis is reviewed at the end of each treatment. The duration and frequency of the treatment plan depends on the patient's progress. The patient is kept informed throughout this process and will be advised of any need for referral.

6 Appropriateness of Treatment ¹⁸

The indication for osteopathic treatment is the presence of somatic dysfunction that is clinically significant. Clinical significance is determined using the models of osteopathic practice described in chapter 3.1.

¹⁸ WHO Draft: Guidelines on safety and practice of osteopathy and osteopathic medicine

When employed by skilled and knowledgeable individuals, the principles of osteopathy and the osteopathic model of health care may be applied in many clinical conditions.

As primary contact health care providers, osteopaths have responsibility to diagnose and refer patients as appropriate when the patient's condition requires medical, surgical or other therapeutic intervention which falls outside the realm of the osteopath's training. Osteopaths need to recognize when specific approaches and techniques may be contraindicated in specific conditions.

It is important to understand that a contraindication to osteopathic manipulative treatment in one area of the body may not preclude osteopathic treatment in a different area.

Likewise, a contraindication for any specific technique does not negate the appropriateness of a different type of technique in that same patient. Absolute and relative contraindications for osteopathic treatment are usually based upon the technique employed. It is the responsibility of the osteopath to discern which types of techniques are safe and appropriate in a clinical situation.

Direct techniques, such as muscle energy, thrust and articular manoeuvres, pose different risks than indirect, fluid and reflex based techniques. There is scant data published that details which techniques should be avoided in specific conditions. An understanding of the pathophysiology of the patient's condition and the mechanism of action of the technique have been used to establish biological plausibility for the absolute and relative contraindications listed.

7 Contraindications¹⁹

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

7.1 Direct techniques

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

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

¹⁹ WHO Draft: Guidelines on safety and practice of osteopathy and osteopathic medicine

7.1.2 Relative contraindications to direct technique

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

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

- aortic aneurysm
- acute hydrocephalus
- hydrocephalus without diagnostic workup
- acute intracerebral bleed
- acute cerebral ischemia, including transient
- suspected arterial-venous malformation
- cerebral aneurysm
- acute cholecystitis with suspected leakage or rupture
- acute appendicitis with suspected leakage or rupture
- acute or subacute closed head injury
- acute disc herniation with progressive neurological signs
- evidence of vascular compromise:
 - carotid bruit
 - aortic bruit
 - ocular bruit
- suspected vertebral artery compromise
 - syncope
 - vertigo
 - known congenital malformation
- acute cauda equina syndrome
- ocular lens implant (early post-operative period)
- uncontrolled glaucoma
- neoplasm
- suspected or risk of bone compromise such as osteomyelitis, bony tuberculosis, etc.

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

- specific technique at the site of internal fixation
- compromised bone or joint stability as might occur focally in neoplasm, metastatic disease, suppurative arthritis, septic arthritis, rheumatoid diseases, osteomyelitis, bony tuberculosis, etc.
- acute fractures (although physicians may appropriately use mobilization/

manipulation to reduce a dislocated joint or comminuted or displaced fracture, this may or may not be performed under anesthesia)

- bony or intramuscular hematoma

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

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

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

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

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

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

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

- metastatic disease
- neoplasm
- acute closed head injury

8 Suggestions

Several countries of the EU have described osteopathy in a law. Therefore osteopathy and her osteopaths are protected in that country by governmental organizations (GO). In most of

the EU member states this is not the case. In these countries only the title DO MRO® is protected. In order to be able to work together osteopathy needs a voluntary system of non-governmental organizations (NGO) installed by the profession itself. This system needs mutual recognition. These GO's and NGO's can work together in the interest of osteopathy and create an European institution where osteopathy and its osteopaths are described and therefore anchored.

This SOPE can not be on its own. Although there are good documents produced by EFO and FORE they are not enough. We, the SOPE-group, think it is necessary to describe the competences of an osteopath as well.

We hope EFO and FORE will consider this proposition of the SOPE-group. We hope EFO and FORE will discuss this proposition with their members. Of course the members of the group will help and continue working with the feedback coming from the osteopaths in Europe.

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Appendix I

Other definitions of osteopathy

“Osteopathy is a system of medicine that emphasizes the theory that the body can make its own remedies, given normal structural relationships, environmental conditions, and nutrition. It differs from allopathy primarily in its greater attention to body mechanics and manipulative methods in diagnosis and therapy.”

World Health Organization (WHO)

“Osteopathy is an established recognised system of healthcare which relies on manual contact for diagnosis and treatment. It respects the relationship of body, mind and spirit in health and disease; it lays emphasis on the structural and functional integrity of the body and the body's intrinsic tendency for self-healing. Osteopathic treatment is viewed as a facilitative influence to encourage this self-regulatory process. Pain and disability experienced by patients are viewed as resulting from a reciprocal relationship between the musculoskeletal and visceral components of a disease or strain.”

World Osteopathic Health Organization (WOHO)

“Osteopathic medicine is a science, an art and a philosophy derived of [sic] health care supported by expanding scientific knowledge. Its philosophy embraces the concept of the unity of the living organism as structure and function. Its art is the application of its concepts to medical practice in all its branches and specialities. Its science includes among others the behavioural, chemical, physical and biological knowledge related to the establishment and maintenance of health as well as the prevention and alleviation of disease. Osteopathic concepts emphasise the following principles:

- *The human body through a complex equilibrial system tends to be self-regulatory and self-healing in the face of disease processes;*
- *The human body is a unit in which structure and function are mutually and reciprocally interdependent;*
- *A rational treatment regimen is based on this philosophy and these principles. It favours a diagnostic approach and manual therapy.”*

European Convention of Osteopathy, Brussels 1987

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The biomechanical model:

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Draft

Appendix IV

Most common used diagnostics tools used by osteopaths:

- Inspection.
- Range Of Motion (ROM).
- Classical orthopedic tests.
- Classical neurological tests.
- Percussion and auscultation.
- Palpation (of position and of movement/static and dynamic).
- Tender Points (Jones techniques) and Triggerpoints.
- Muscle function testing.
- Fascial testing.
- Examination of visceral mobility.
- Examination of the cranium (neuro- and viscerocranium).
- Examination of neurolymphatic reflexes (Chapman reflexes).
- ...

Assessment of a somatic dysfunction:

- A static and dynamic morphologic inspection (with a qualitative and a quantitative evaluation of movement).
- Evaluation of function.
- Evaluation of pain.
- Evaluation of asymmetry.
- Evaluation of tissue texture.

Treatment consists primarily of manual acts, such as:

- Structural “High Velocity Low Amplitude” (HVLA-techniques, mobilization with impulse).
- Toggle techniques.
- Percussion vibrator technique.
- “Muscle Energy Techniques” (MET) (techniques in which neuromuscular reflexes are being used).
- General osteopathic mobilizations (General Osteopathic Treatment. (GOT), Total Body Adjustment (TBA))
- Functional techniques (Sutherland-, Hoover-, Jones or counterstrain-techniques, balanced ligamentous tension (BLT), ...
- Progressive inhibition of neuromuscular structures (PINS).
- Fascial techniques (myofascial release-, Chila-techniques, unwinding-techniques,).
- Soft tissue techniques.
- Neurovisceral and neurolymphatic reflex techniques.

- Fluida techniques (lymphatic pump techniques, ...).
- Visceral manipulation.
- Neurocranial and viscerocranial techniques.
- ...

Appendix V

Members of the committee:

José Apeztegia Fiel DO, president of the Consejo Espanol de Osteopatas

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NVO is member of the EFO; the Dutch osteopaths registered with the Dutch register NRO are registered with the EFO register and Ton represents NVO and NRO in FORE.
Chair of the Scope of Osteopathic Practice in Europe committee.

Philippe Sterlingot DO, France

Michael Watson member of the board of the EFO, representing the BOA (British Osteopathic Association) in the EFO. Representing the EFO at FORE meetings.

Appendix VI

Here you can find the data about osteopathy in Europe:

- Number of osteopaths registered
- Registers
- Associations
- Schools
- Regulation
- etc

Draft