



CEN/TC 414
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Please find enclosed a proposal for the content for a European Standard for Osteopathic Healthcare Provision. When the suggested items are accepted in principle it will be structured according to the obligatory format of a CEN draft standard.

**Draft European Standard for
Osteopathic Healthcare Provision**

Working Dokument

Section 1: Introduction

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1. Introduction

- 1.1. Osteopathy is a popular and progressive, patient-centred healthcare discipline. Patients who choose osteopathic treatment must be assured of the quality and the standard of care that they will receive.
- 1.2. This standard is concerned with the provision of osteopathic treatment and care. It aspires to set a standard that provides for high quality clinical practice, education, safety and ethics for the benefit of patients.
- 1.3. This European Standard does not supersede national legislation.

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2. Definition and Structure of Osteopathy

Definition of Osteopathy

- 2.1. Osteopathy is a branch of healthcare, which was developed by an American physician, Andrew Taylor Still (1828-1917), who established the first school of osteopathy in 1892. Osteopathy is a widely recognised graduate-level healthcare discipline and has spread from the USA to Europe and elsewhere.
- 2.2. Osteopathy is based on anatomy, physiology, embryology and other medical sciences. The approach to healthcare is patient-centred and focused on the patient's health rather than disease-centred.
- 2.3. Osteopathy sees the human being as a unit of body, mind and spirit and uses the function of the body as a holistic linked feedback control system. The aim of osteopathic practice is to identify restrictions of function and movement and to release these.
- 2.4. Osteopaths recognise an expression of movement in all functional aspects of the organism. They induce a self-regulatory process of regeneration to enable the patient to regain their own dynamic balance and homeostasis.
- 2.5. Osteopaths rely on the healing process that is mainly mediated by hand contact but is also supported with all their abilities and knowledge.
- 2.6. The aim of osteopathic treatment is to improve and support all aspects of health and healthy development.

Integration of Models

- 2.7. The terms osteopathy and osteopathic medicine are sometimes used interchangeably. Osteopathy is sometimes seen as an independent healthcare discipline or speciality of healthcare, but with the potential of integration with other disciplines.
- 2.8. The osteopathic approach is based on principles drawn from human physiology, anatomy, embryology and other medical sciences. In consequence of the complexity of the human organism there are a number of different models that are used in the osteopathic approach. These recognisable models can be described in different ways – depending on the actual scientific results and the currently derived worldview. It is important that osteopathy retains its identity while also adapting to new knowledge.
- 2.9. The models set out in Annex A articulate how an osteopathic practitioner seeks to influence a patient's physiological responses. These models influence the gathering of diagnostic information and the interpretation of the significance of structural findings in the overall health of the patient. Typically a combination of

models will be appropriate for an individual patient. The combination chosen is based upon physical, emotional, cognitive and spiritual characteristics of the individual, modified by the patient's differential diagnosis, co-morbidities, and other therapeutic regimens. The combination of models must be adapted to reflect the patient's response to treatment.

- 2.10. Different osteopaths might favour different models, but as the patient's organism doesn't separate the models, the osteopath regards the unity of the body, mind and spirit as like the unity of different models in every treatment. The combination of models must be adapted to reflect the patient's response to treatment. The osteopath must be able to select or modify techniques to meet the needs of an individual patient.
- 2.11. Osteopaths are trained to consider the patient as a whole and how the patient presents themselves for treatment will be influenced by their individual physical, mental and emotional health. The highly developed sense of touch and attention to complex systems as a unit is typical for an osteopathic approach.
- 2.12. The models have a basis in scientific research but must be integrated into clinical practice through practical experience and observation of their distinct effects on the body as a whole. For an ultimate understanding of the models it is essential to get practice on the experiential evidence of the distinct body effects.

3. Clinical practice

- 3.1. Osteopathy is patient-centred and focused on the patient's health rather than disease-centred. Osteopathic treatment always considers the pathophysiological processes. Osteopaths must have and cultivate an understanding of models of health and disease and how these inform a critical consideration of practical patient care and management. They should have a critical awareness of relevant high quality research and of principles and practice of other relevant healthcare approaches for adequate referral, cooperation and adjuvant treatment. The osteopath's relationship with their patient shall be caring, neutral and non-judgmental.
- 3.2. Osteopaths analyse the regular functional processes of the organism and use recognised principles in the individual diagnosis and treatment of every patient.
- 3.3. These principles are:
 - The human being is a dynamic unit of function, a unit of body, mind and spirit.
 - Structure and function are interrelated at all levels.
 - The human being possesses self-regulatory mechanisms that maintain the integrity with its intrinsic tendency of self-healing. Osteopaths treat in a way that induces a self-regulatory process of the patient, because they trust in the self-healing forces of the body.
 - The human being always tries to regain its own dynamic balance and establish homeostasis.
 - The human being works as much as it can in an economic and comfortable way.
 - The human being responds as a whole to disease and shows patterns of function. If one part is changed in the system, the balance of the whole pattern will be affected.
- 3.4. To apply these principles is typical for osteopathic treatment. Osteopathy does not consist just of a series of techniques but of a broad range of technical abilities that are used for application of the principles. These principles are not simply philosophical, but also very concrete and practical instructions for treatment. Knowing and following these models and principles, changes completely the intention of the treatment. Although other disciplines might acknowledge some of these principles, osteopathy acknowledges them all together and uses them in a unique and special way.

Case History, examination and interpretation of the findings

- 3.5. Osteopaths should take a detailed case-history of the patient and analyse the patient's presenting complaint. They should be able to interpret verbal and non-

verbal information. This information should be individually recorded and stored safely. Confidentiality must be maintained at all times.

- 3.6. It is necessary to listen to patients and respect their concerns and preferences. Osteopaths should be able to recognise the characteristics and consequences of non-verbal communication and issues of ethnicity, gender, religious beliefs, sexuality, disability and socio-economic status as they may impact on the patient's health.
- 3.7. Osteopaths have to give patients the information they need and in a way they can understand and benefit from. There has to be an explanation of benefits and risks and as a result, consent given by the patient for the treatment/procedure.
- 3.8. Osteopaths should be able to generate a number of diagnostic hypotheses to explain the aetiology of the patient's presenting complaint to aid the formulation of a treatment strategy or referral to another healthcare professional.
- 3.9. Osteopaths should be able to select an appropriate course of action based on rational decision-making process which includes a critical consideration of personal limits of competence, the likely effects of osteopathic treatment, relevant high-quality research and the patient's wishes.
- 3.10. Osteopaths should demonstrate a detailed expertise of human structure and function, with great emphasis on functional interrelation of all the systems of the body. This should be sufficient to recognise, identify and differentiate between normal and abnormal structures and processes in the living body. Osteopaths consider and recognise through an understanding of the models and principles that the presenting problem may be caused by underlying health concerns.
- 3.11. Osteopaths should be able to conduct an effective biomechanical assessment of the patient and to undertake a thorough, sensitive and appropriately detailed palpatory evaluation for the other models.
- 3.12. These high quality palpatory skills and manual contact for diagnosis and treatment are essential for osteopathic practice. Osteopaths should use the diagnostic advantage of manual examination to have a rational base for decision making and to determine whether diagnostic imaging such as X-ray or MRI, or further specific clinical investigations are necessary for a patient.
- 3.13. Osteopaths should have a knowledge and understanding of human disease sufficient to inform clinical judgement, and to recognise disorders not suitable for special osteopathic techniques.

Osteopathic treatment

- 3.14. Osteopaths should be able to generate accurate clinical records of the outcomes of the patient evaluation and treatment process.
- 3.15. Osteopathic treatment addresses the functional aspects with consideration of structural conditions. Osteopaths must be able to demonstrate how the models and principles are translated into action through a number of different osteopathic treatment and management approaches.
- 3.16. Osteopaths should be able to select, use and modify a wide range of osteopathic techniques and patient management approaches. Osteopaths should monitor the effect of treatment during and after its application, via verbal and non-verbal feedback and palpation of the tissue-feedback.
- 3.17. Osteopathic treatment might be preventive, curative or adjuvant. Osteopaths should ensure that the patient regains as much of his natural structural integrity and function as possible. If appropriate, osteopaths should enhance the patients understanding and commitment to individual exercise, preventive measures, adapting lifestyle and dietary considerations, as well as making use of local healthcare facilities. Osteopaths should make clear the importance of these aspects and self-care activities for the patient's health. This includes explanation of its potential benefit, risk and limitation.
- 3.18. Osteopaths should help patients to make informed choices about their personal healthcare maintenance. Osteopathic manual treatment (OMT) and other abilities of osteopaths might be used for the education of patients in the understanding of their disorders and how to manage their conditions or prevent recurrence.
- 3.19. Osteopaths must analyse critically and are required to guide the patient to an understanding of the significance of the potential effect of the treatment, the patient's progress against expected outcomes, modifying accordingly the working diagnostic hypothesis, the approach in treatment and the patient's management including changes to their lifestyle to improve and maintain their health. This includes self-care activities like sports, diet and exercise.
- 3.20. Osteopaths should be able to recognise adverse reactions to osteopathic treatment and to initiate appropriate responses, including referral when appropriate.
- 3.21. Osteopaths, the whole practice team and patients should work in partnership, as effective interaction of all involved provides optimal care.
- 3.22. Osteopathic practice facilities should meet the need of the patients for confidentiality and optimal cooperation in the treatment process. This includes adherence to national health and safety standards.

3.23. Osteopathic treatment should normally be delivered in practice facilities that are hygienic, safe and conducive to the delivery of high-quality healthcare.

Diversity in the osteopathic profession

3.24. During its history, osteopathic practitioners seeking to address the complexity of human physiology have articulated a variety of models of approach based on common principles.

3.25. Osteopathy is recognised as distinct from other healthcare professions that utilise manual techniques, such as physiotherapy and chiropractic. Osteopathic education, professional associations and international associations are independent of these other professions.

3.26. Osteopaths are encouraged to avoid isolation as practitioners and to join a national osteopathic association or, where no such body exists, work with colleagues to form an association. Existing osteopathic organisations are encouraged to work in cooperation to promote high standards of osteopathy.

3.27. An essential component of osteopathy is structural diagnosis and osteopathic manual treatment. Although manual techniques are used by many types of practitioners, such as chiropractors, manual therapists, physiotherapists, tuina and craniosacral therapists. The unique manner in which osteopathic manual techniques are integrated into patient management, the duration, frequency and the choice of technique are distinctive aspects of osteopathy. Osteopathic manual treatment (OMT) is not limited to the spinal thrust techniques often associated with manual medicine. Many forms of osteopathic manual techniques are taught and used by osteopaths. These include thrust or impulse techniques as well as very gentle techniques (a range of techniques employed by osteopaths can be found in Annex C).

4. Education and Training

Forms and/or categories of education

- 4.1. Regulating the practice of osteopathy and preventing practice by unqualified practitioners requires a proper system of training, examination and licensing.
- 4.2. Benchmarks for training have to take into consideration the subsequent items:
 - a. Content of the training;
 - b. Method of the training;
 - c. To whom the training is to be provided and by whom;
 - d. The roles and responsibilities of the future practitioner;
 - e. The level of education required in order to participate in osteopathic training.
- 4.3. There are two types of training depending on prior training and clinical experience of trainees.
 - a. Type I training programmes are aimed at those with little or no prior health-care training, but who have completed high school education or equivalent.
 - b. Type II training programmes are aimed at those with prior training as health-care professionals.
- 4.4. A typical Type I programme would take 4800 hours, including at least 1000 hours of supervised clinical practice and training. Osteopathic skills and physical examination training must be delivered via direct contact. Other academic curricular content may be delivered by various staff and in various training formats. Training may be full-time, part-time or a combination of the two.
- 4.5. Osteopathic manual treatment is a distinctive component of osteopathy. It requires both cognitive and sensory motor skills, and knowledge, and the development of these clinical and manual skills requires time and practice. The length and content of a Type II programme will be adapted according to the theoretical knowledge obtained during the individual's prior training, and typically be not less than 1200 hours. Type II programmes must cover osteopathic core competencies including knowledge, understanding and application of the osteopathic models. Graduates of Type II programmes must also demonstrate the same practical competencies of osteopathy, including sensorimotoric skills and application of osteopathic principles in treatment, as graduates of Type I programmes.
- 4.6. Supervised osteopathic clinical practice is an essential component of the training of osteopathic practitioners and should take place in an appropriate osteopathic clinical environment so that high-quality clinical support and teaching can be provided. This will include a minimum of 1000 hours of supervised osteopathic clinical practice in Type I and Type II programmes.

- 4.7. The osteopathic learning outcomes for both Type I and Type II programmes should be at Level 7 on the European Qualifications Framework.
- 4.8. Both Type I and Type II programmes should be externally validated or assessed with appropriate osteopathic input.

General ideas on osteopathic education

- 4.9. Osteopathic practitioners share a set of core competencies that guide them in the diagnosis, management and treatment of their patients and form the foundation for the osteopathic approach to health care. The following are essential competencies for osteopathic practice in all training programs:
 - a. Osteopathic history, philosophy, and approach to health care;
 - b. Basic sciences within the context of the philosophy of osteopathy;
 - c. Differential diagnosis and treatment plan;
 - d. Knowledge of the mechanisms of action of manual therapeutic interventions and the biochemical, cellular and gross anatomical response to therapy;
 - e. Ability to appraise medical and scientific literature critically and incorporate relevant information into clinical practice;
 - f. Competency in the palpatory and clinical skills necessary to diagnose dysfunction in the aforementioned systems and tissues of the body, with an emphasis on osteopathic diagnosis (see Annex A);
 - g. Competency in a broad range of skills of OMT;
 - h. Proficiency in physical examination and the interpretation of relevant tests and data, including diagnostic imaging and laboratory results;
 - i. An understanding of osteopathic models (see Annex A) this includes but is not limited to biomechanics of the human body including, but not limited to, the articular, fascial, muscular and fluid systems of the extremities, spine, head, pelvis, abdomen and torso;
 - j. Expertise in the diagnosis and OMT of neuromusculoskeletal disorders and disorders related to functional support within the osteopathic models;
 - k. Thorough knowledge of the indications for osteopathic treatment, and contraindications to special osteopathic techniques;
 - l. A basic knowledge of commonly used traditional medicine and CAM techniques.

Core competencies: the context of osteopathic education

4.10. Basic sciences

- i. History and philosophy of science;
- ii. Gross and functional anatomy, including basic embryology showing the link to osteopathic understanding and treatment, neuroanatomical and visceral anatomy;
- iii. Fundamental microbiology, biochemistry and cellular physiology;

- iv. Training of osteopathic practitioners;
- v. Physiology with special emphasis on the neuroendocrine immune network, the autonomic nervous system, the arterial, lymphatic and venous systems and the musculoskeletal system;
- vi. Biomechanics and kinetics.

4.11. Clinical sciences

- i. Models of health and disease;
- ii. Safety and ethics;
- iii. Basic pathology and pathophysiology of the nervous, musculoskeletal, psychiatric, cardiovascular, pulmonary, gastrointestinal, reproductive, genito-urinary, immunological, endocrine and otolaryngology systems;
- iv. Basic orthopaedic diagnosis;
- v. Basic radiology;
- vi. Nutrition;
- vii. Basic emergency care.

4.12. Osteopathic sciences

- i. Philosophy and history of osteopathy;
- ii. Osteopathic models for structure/function interrelationships (see Annex A and Section 3.4 above);
- iii. Clinical biomechanics, joint physiology and kinetics;
- iv. Mechanisms of action for osteopathic techniques.

4.13. Practical skills

- i. Obtaining and using an age-appropriate history;
- ii. Physical and clinical examination;
- iii. Osteopathic diagnosis and differential diagnosis of the nervous, musculoskeletal, psychiatric, cardiovascular, pulmonary, gastrointestinal, endocrine, genito-urinary, immunological, reproductive and otolaryngology systems;
- iv. General synthesis of basic laboratory and imaging data;
- v. Clinical problem-solving and reasoning;
- vi. Understanding of relevant research and its integration into practice;
- vii. Communication and interviewing;
- viii. Clinical documentation;
- ix. Basic life-support and first-aid care.

4.14. Osteopathic skills

- i. Osteopathic diagnosis;
- ii. There is a wide spectrum of osteopathic techniques, (see Annex C), at a minimum the following techniques should be included:
 - Osteopathic techniques, including direct techniques such as thrust, articulatory, muscle energy and general osteopathic techniques;
 - Indirect techniques, including functional techniques and counterstrain;

- Balancing techniques, such as balanced ligamentous tension and ligamentous articular strain;
- Combined techniques, such as myofascial/fascial release, Still technique, osteopathy in the cranial field, involuntary mechanism and visceral techniques;
- Reflex-based techniques;
- Fluid-based techniques.

Osteopathic teaching, learning and assessment

Teaching and learning

4.15. Teaching and learning in osteopathy programmes will take place in a combination of the following contexts:

- i. Lectures: they should convey and comment upon core subject matter, stimulate critical thinking and debate, and encourage students to extend their own knowledge and understanding;
- ii. Workshops and seminars: they may commonly involve small group work, skills development, discussions and student presentations;
- iii. Tutorials: they may support the process of self-assessment and tutor guidance and feedback. They may also provide support for individual or group work and for dissertation preparation;
- iv. Self-managed or self-directed learning: this is an important part of any degree programme in osteopathy. It may involve preparation for specific assignments, reflection/discussion, practice of osteopathic techniques, and the use of resource-based learning, including learning resources made available in electronic and other formats. Students will normally undertake their own individual osteopathy related research project or study. It is important that students are adequately prepared, guided and supported in developing and maintaining effective strategies for self-managed learning.

Practical skills

4.16. The acquisition of practical osteopathic skills requires students to work on peers and, in turn, to experience taught techniques as 'models' prior to application in a clinical context.

4.17. Palpation and osteopathic technique should be taught in specialist accommodation utilising appropriate equipment. Provision for students to review and assess their performance of their osteopathic practical skills through the use of regular tutor feedback in this area is ideal and critical. Video recording and playback is required to improve practical approach and psychosocial interaction.

4.18. It is important that teaching and supervision in practical osteopathic technique skills is performed by suitably qualified osteopaths, registered with the relevant national Register or Competent Authority where these exist.

Clinical education

- 4.19. It is essential that clinical learning experience provides appropriate opportunities for students to develop not only patient evaluation and treatment skills, but also the ability confidently to recognise pathologies for referral and contra-indications to special osteopathic techniques.
- 4.20. The clinical learning environment should be a focus for the integration and practical application of all theoretical, practical, and technical knowledge and skills across the programme. It should provide the student with a supportive, broad, progressive and well supervised environment in which to develop their clinical skills.
- 4.21. It is expected that students will undertake substantial supervised osteopathic clinical practice within a dedicated teaching clinic where they can observe senior students and qualified practitioners in the early stages of their training, progressing to take an increasing responsibility for their own patient lists as their experience and knowledge develop.
- 4.22. The following arrangements for osteopathic clinical education are to be expected:
- i. adequate/appropriate learning opportunities for developing professional skills with real patients, paying due regard to case history taking, examination, evaluation and differential diagnosis, treatment and development of treatment plans, record-keeping, follow-up and referrals;
 - ii. opportunities to integrate academic and theoretical learning and to develop practical skills within the therapeutic clinical encounter;
 - iii. adequate numbers for each student of new, returning and continuing patient encounters and exposure to an appropriate range of presenting conditions;
 - iv. appropriate staff student ratios within the clinical setting allowing for close supervision of patient encounters by tutors, and opportunities for clinical tutorials;
 - v. appropriate opportunities for junior students to learn from observation of more senior student practitioners and for senior students gradually to take over responsibility for their own lists and to develop autonomy in patient care;
 - vi. appropriate settings for clinic education within a dedicated training clinic with adequate treatment and educational accommodation, and appropriate equipment and furnishings for high quality student experience and patient care;
 - vii. appropriate clinical administrative infrastructures to support student learning and patient care;
 - viii. arrangements for on-going assessment and feedback from a variety of clinical tutors;
 - ix. opportunities to develop practice management skills;
 - x. effective mechanisms for monitoring individual student clinical attendance, caseloads, and patient list profiles;

- xi. effective mechanisms for ensuring that high standards of osteopathic care and the safety of patients are maintained by guiding, developing and monitoring the professional conduct of students treating patients.

4.23. Arrangements for clinical education may be varied for Type II programmes depending on the prior clinical knowledge and experience of students.

Assessment

4.24. Students of osteopathy must master a wide range of knowledge and skills as indicated above, and they must be able to demonstrate an ability to integrate and apply their learning as safe and effective healthcare practitioners. In achieving this it is also important that empathy with ethical behaviour towards patients, ethical conduct towards colleagues and others, and general behaviour consistent with that of an aspiring healthcare professional is demonstrated. In order to ensure that all the required learning outcomes are met and that students progress satisfactorily through the programme, a range of assessment strategies will need to be employed.

4.25. These assessment strategies may include:

- i. Demonstration of clinical competence and practice: including the ability to draw on, synthesise and apply knowledge and skills for safe and effective patient management. Methods of assessment will vary, but will always include the requirement for students to demonstrate skills working with a range of new and continuing patients. So as to ensure comparability of practitioner standards for entrants to the profession, it is essential that external examiners are physically present at some of the practical assessments with real patients in a real clinical scenario;
- ii. Practical examinations: in which students demonstrate their skills in selecting and performing a range of safe and effective osteopathic techniques.
- iii. Written examinations: under timed conditions, requiring students to work and think under pressure/usual examination conditions, assessing knowledge-base, understanding and analytical skills;
- iv. Dissertations or other pieces of extended written work: these are normally related to osteopathic practice and include systematic enquiry, investigation, analysis and evaluation, and should demonstrate the student's ability to apply appropriate analytical methods, whether qualitative or quantitative, and to plan and carry out a research project.

4.26. Other assessment strategies and methods that may be employed include:

- i. Portfolios: collating evidence to support claims that learning outcomes have been met. Portfolios can be a means of capturing and giving proper weight to experience, and may be used to document the acquisition of practical and/or clinical and/or affective skills;
- ii. Essays and other coursework: which enable students to display a broader knowledge of subject matter than in examination papers and test their

- ability to investigate a topic, to organise their material and ideas to a prescribed deadline, and to critically appraise published evidence;
- iii. Computer based assessments;
 - iv. Case study presentations and analyses;
 - v. Oral presentations: testing presentation and communication skills in an individual or group situation;
 - vi. Analytical exercises: including 'paper patient' exercises and Objective Structured Clinical Examination and Objective Structured Practical Examination type assessments.

4.27. Quality assurance/control mechanisms for assessment should ensure external assessor review independent of the educational provider. This will provide a greater likelihood of consistent standards and will deter potential commercial exploitation of osteopathic education and training.

4.28. It is important that assessment strategies are regularly reviewed, with programme providers ensuring that best contemporary practice in this area is evaluated and applied where appropriate. The validity and reliability of assessment should be considered carefully.

4.29. As with clinical education, arrangements for assessment may be varied for Type II programmes depending on the prior knowledge and experience of students.

Osteopathic postgraduate and continued education and formation

4.30. Osteopaths must maintain and develop their knowledge and skills of osteopathic treatment and science through continuing professional development.

4.31. Continuing professional development should seek to maintain, improve and broaden the osteopathic knowledge and skills of the graduated osteopaths and develop the personal qualities required in their professional lives.

4.32. Depending on the countries legal regulations a form of accreditation should be installed to ensure the continued formation of the osteopath in the field.

5. Ethics

- 5.1. The provision of osteopathy must be based on high standards of ethical and professional behaviour. The standards in Annex B set out the key principles that must be observed by osteopaths in their interactions with patients, prospective patients and other osteopaths and healthcare professionals.

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6. Glossary

Osteopath

6.1. The osteopath is a primary healthcare provider who applies osteopathy (which sometimes is also called osteopathic medicine) to patients and might be recruited from different professions, physicians and non-physicians, depending to different nations with different laws. Through these different origins there are different abilities and knowledge, but due to applying Osteopathy to patients, there must be osteopathic minimum standards for their osteopathic practice.

Osteopathic manual treatment (OMT)

6.2. Osteopathic manual treatment is a manual approach to a patient applied by an osteopath supporting the body in its regeneration and healing process. Induction of the self-regulating process is the core of all techniques while there are different possibilities to apply these techniques, which are e.g. direct, indirect and neutral techniques. Osteopathy is different to other manual therapies especially in the difference of intention at manipulations. Most patients sense and notice this difference in the kind of approach. A list of common OMT techniques can be found in Annex C.

Dysfunction

6.3. Dysfunctions are areas with restricted expression of normal function, normal movement and normal dynamic at any level. They are areas of tissue strain or stress, which might impede normal biomechanical (e.g. joint restriction), neuroelectrical, vascular, biochemical or cellular function and cause a decrease of health by that way.

Annex A – Osteopathic models

- A1. There are a number of different models used by osteopaths in Europe. Although not an exhaustive list, these include the following.
- A2. Some of the models include the prefix 'Bio' (bio, latin = life), which highlights the speciality of these categories. For example biomechanics is not only mechanics, but also how life expresses itself in a mechanical way.

Biomechanical Model

- A3. This model views the body as an integration of structural components that relate as a posture and balance mechanism. Stresses or imbalances within this mechanism will lead to decreased dynamic function, increased energy expenditure, dysfunctional neuromuscular movement patterns in the infant development and the adult, altered proprioception (one's sense of the relative position and movement of neighbouring parts of the body), changes in joint structure, impediments of neurovascular function and altered metabolism. This model applies therapeutic approaches, including osteopathic manual treatments that allow for restoration of posture and balance and efficient use of the musculoskeletal components.

Craniosacral Model

- A4. The craniosacral model, rather '*osteopathy in the cranial field*' relates to the tissue dynamic of the whole body via the brain, spinal cord and adjacent structures like liquor cerebrospinalis, meninges, the sacrum and cranial bones. The model considers the effects of the neurological system, respectively cerebral and spinal facilitation, proprioceptive function, balance between the components of the autonomic nervous system, and activity of nociceptors (pain fibres) on the function of the neuro-endocrino-immune network. Of particular importance is the interrelatedness of the musculoskeletal and visceral systems e.g. through the autonomic nervous system, fascial interconnections or the general and specific tissue dynamic. Therapeutic application of osteopathic manual treatment within this model focuses on the adequate and economic response to stresses, balance of neural inputs and the elimination of nociceptive drive.

Metabolic/Circulatory Model

- A5. 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. The resultant metabolic field has chemo-mechanic transduction effects, which works in both directions. Tissue stress or other factors interfering with the flow or circulation of any body fluid can affect tissue health and the functional state of the viscera in motion and mobility. Any stress on the vessels or biochemical balance might also influence cellular regeneration. This is conducted via vascular pericytes, who are stem cell

progenitors and are responsible for tissue regeneration. Therapeutic application of osteopathic manual treatment within this model would address functional improvement in respiratory function, visceral function, circulation, vascular balance and the flow of body fluids.

Biopsychosocial Model

- A6. This model looks at the interaction between psyche and body, various reactions and psychological stresses with which the patient has to cope with. Health may be affected by environmental, socioeconomic, cultural, physiological and psychological factors towards dysfunction. Disorder of psychological conditions may affect the somatic body as well as dysfunctions of the somatic body may affect the psychological state of health. This underlines the interdependence of body, mind and spirit. Therapeutic application of osteopathic manual treatment addresses the balance of the somatic body and the psyche.

Biophysical/Bioenergetic Model

- A7. The biophysical/bioenergetic model recognizes that the body seeks to maintain a dynamic balance between energy production, distribution and expenditure. Maintaining this dynamic balance aids the organism in its ability to adapt to various stressors (immunological, physical (e.g. temperature), nutrition, toxins, etc.). This model applies therapeutic approaches, including osteopathic manual techniques, to address the factors, which have the potential to improve the regulation of the production, distribution or expenditure of energy.

Annex B – Ethics

Acting in the patient interest

- B1. The osteopath must make their main priority the health and wellbeing of the patients in their care.
- B2. The osteopath must at all times be honest and trustworthy in their dealings with patients, colleagues and other healthcare professionals. The osteopath should not use their professional position to place undue pressure of any kind on their patients.
- B3. Every patient must be treated as an individual and with consideration, dignity and respect; the osteopath must never allow care to be prejudiced by their views about patients. This includes their gender, ethnicity, disability, culture, religious or political beliefs, sexuality, lifestyle, age, social status, language difficulties or any other characteristic. The osteopath's own values, beliefs and attitudes must not come before the overriding interest of a patient's wellbeing.
- B4. The osteopath must respect the choice of the patient on whether to consult the osteopath and to accept or decline the treatment that the osteopath recommends. Equally, the osteopath is under no obligation to examine or treat a patient if they do not wish to do so.
- B5. The osteopath must maintain clear professional boundaries with their patients and must not abuse their professional position.

Working in partnership with the patient

- B6. The osteopath must take reasonable care using their professional knowledge and skills to advise and provide appropriate treatment for their patients making it clear to patients, as osteopaths, what they can and cannot offer.
- B7. The osteopath must provide the patient with clear information about the fees or scale of fees that they will be charged for their examination, treatment and any other aspect of care.
- B8. The osteopath should listen to the patient and respect their views, values and preferences, encouraging them to take an active part in any decisions about their treatment and care, including providing advice on self-care.
- B9. The osteopath should explain to their patients in ways that they can understand the reasons for any examination or treatment, the benefits as well as any potential side-effects or serious risks from the treatment.
- B10. The osteopath should obtain consent from a patient before examination or treatment of a patient and where appropriate continues to seek consent as treatment progresses.

- B11. The osteopath should ensure that the patient's modesty is respected.
- B12. The osteopath must make sure the patient is aware of their rights, particularly to stop an examination or treatment at any time and also to be accompanied by a chaperone if they wish.
- B13. Where written consent is not already required by law, if the examination or treatment proposed is intimate in nature the osteopath is advised to seek written consent.
- B14. The osteopath must comply with any additional legal requirements for obtaining consent for the treatment of children or others who may not be able to give consent.

Maintaining public trust and confidence in the osteopathic profession

- B15. The osteopath must recognise and work within the limits of their knowledge, skills and competence. The osteopath must never claim to have skills they do not have and should refer, where necessary, to a more appropriate health professional.
- B16. The osteopath must ensure that they do not provide an excess level of treatment, treatment that is not required, or in any way put commercial gain above the needs of the patient.
- B17. The osteopath must not make misleading claims about the effectiveness of osteopathic treatment and must comply with relevant national and EU laws on marketing and promotion.
- B18. The osteopath must act quickly to protect patients if there is good reason to believe that they or a colleague may be putting patients at risk, either by reporting this to an appropriate authority, or in the case of the osteopath themselves ceasing to provide treatment to patients.
- B19. The osteopath should operate a procedure for considering and responding to complaints against their practice and they should respond promptly and constructively to criticism and complaints
- B20. The osteopath should refrain, even outside their practice of osteopathy, from any act likely to damage the reputation of the osteopathic profession.
- B21. The osteopath should respect the skills of other osteopaths and healthcare professionals, and communicate and work in co-operation with them for the continuity of care and benefit of patients.
- B22. Where the osteopath cannot make themselves available to a patient, they should ensure, as far as possible, that they have access to another osteopath. The osteopath must not delegate osteopathic treatment to an individual who is not a qualified osteopath.

B23. The osteopath should ensure that they maintain personal liability insurance appropriate for their practice.

B24. The osteopath must comply with any regulations or legal requirements in force in the country or jurisdiction in which they practise osteopathy. Any such legal requirements shall also supersede the requirements in these standards.

Maintaining, respecting and protecting patient information:

B25. The osteopath must make and maintain a full and accurate clinical record for each patient and make appropriate information available to the patient on request. It may be appropriate for that record to include:

- i. The patient's personal details;
- ii. Any problems and symptoms reported by the patient;
- iii. Relevant medical and family history;
- iv. Clinical findings;
- v. The information and advice provided;
- vi. Actual advice given to the patient regarding the risks associated with any proposed examination or treatment;
- vii. The decisions made;
- viii. Records of consent and/or consent forms;
- ix. The investigation and treatment provided or arranged, and their results;
- x. Any additional communication in any form with, about or from the patient;
- xi. Copies of any correspondence, reports, test results, etc. about the patient;
- xii. Reaction to treatments/treatment outcomes;
- xiii. Reference to any home/domiciliary visit;
- xiv. If a chaperone was present or was not required;
- xv. Whether a student/observer was present.

B26. The osteopath must maintain confidentiality about all the information they have obtained in the course of the consultation, examination or treatment of a patient, unless otherwise specified by law.

B27. Confidentiality requires secure retention and storage of information even after the individual is no longer the patient of the osteopath or after they are deceased or in compliance with any existing national standards where these are different.

B28. Information about patients must not be transferred to any other person, including another osteopath or healthcare professional who may be involved in the treatment of the patient or for research purposes (including any staff of the osteopath), without the consent of the patient and having provided them with a clear understanding of the reasons for doing so, unless such sharing of information is permitted by national law or circumstances.

Working in partnership with other healthcare providers

B29. Osteopathy has the potential to enrich all medical disciplines, by acknowledging the osteopathic principles. There should be interdisciplinary communication for optimal enhancing of the patients health and for optimal development of all medical professions.

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Annex C – Osteopathic Manual Treatment (OMT)

C1. The therapeutic application of manually guided forces by an osteopath to improve physiologic function and/or support homeostasis that has been altered by dysfunction. OMT employs a variety of techniques including:

- **Active method**, technique in which the person voluntarily performs an osteopathic practitioner-directed motion.
- **Articulatory treatment**, multiple possibilities to treat a joint. See variations below.
- **Articulatory treatment system (ART)**, a low velocity/moderate to high amplitude technique where a joint is carried through its full motion with the therapeutic goal of increased range of movement. The activating force is either a repetitive springing motion or repetitive concentric movement of the joint through the restrictive barrier.
- **Balanced ligamentous tension (BLT)**, 1. All the joints in the body are balanced ligamentous articular mechanisms. The ligaments provide proprioceptive information that guides the muscle response for positioning the joint and the ligaments themselves guide the motion of the articular components. (Foundations) 2. First described by W.G. Sutherland and published in the *1949 Year Book of Academy of Applied Osteopathy: "Osteopathic Technique of William G. Sutherland"*. Also published by Sutherland in "Teachings in the science of osteopathy". 3. See also *ligamentous articular strain*.
- **Combined method**, 1. A treatment strategy where the initial movements are indirect; as the technique is completed the movements change to direct forces. 2. A manipulative sequence involving two or more different osteopathic manual treatment systems (e.g., Spencer technique combined with muscle energy technique). 3. A concept described by Paul Kimberly, DO.
- **Combined treatment**, See *combined method*.
- **Compression of the fourth ventricle (CV-4)**, a cranial technique in which the lateral angles of the occipital squama are manually approximated slightly exaggerating the posterior convexity of the occiput and taking the cranium into sustained extension.
- **Counterstrain (CS)**, 1. A system of diagnosis and treatment that considers the dysfunction to be a continuing, inappropriate strain reflex, which is inhibited by applying a position of mild strain in the direction exactly opposite to that of the reflex; this is accomplished by specific directed positioning about the point of tenderness to achieve the desired therapeutic response. 2. Australian and French use: Jones technique, (correction spontaneous by position), spontaneous release by position. 3. Developed by Lawrence Jones, DO.
- **Cranial treatment (CR)**, See *primary respiratory mechanism*. See *osteopathy in the cranial field*.
- **Craniosacral treatment**, See *primary respiratory mechanism*. See *osteopathy in the cranial field*.
- **CV-4**. Abbreviation for compression of the fourth ventricle. See *compression of the fourth ventricle*.

- **Dalrymple treatment**, See *pedal pump*.
- **Direct method (D/DIR)**, an osteopathic treatment strategy by which the restrictive barrier is engaged and a final activating force is applied against the direction of restriction to correct dysfunction.
- **Exaggeration method**, an osteopathic treatment strategy by which the dysfunctional component is carried away from the restrictive barrier and beyond the range of voluntary motion to a point of palpably increased tension. This leads to a correcting body response against dysfunction.
- **Exaggeration technique**, an indirect procedure that involves carrying the dysfunctional part away from the restrictive barrier, then applying a high velocity/low amplitude force in the same direction.
- **Facilitated positional release (FPR)**, a system of indirect myofascial release treatment. The component region of the body is placed into a neutral position, diminishing tissue and joint tension in all planes, and an activating force (compression or torsion) is added. 2. A technique developed by Stanley Schiowitz, DO. 3. See *balanced ligamentous tension*
- **Fascial release treatment**, See *myofascial release*.
- **Fascial unwinding**, a manual technique involving constant feedback to the osteopathic practitioner who is passively moving a portion of the patient's body in response to the sensation of movement. Its forces are localized using the sensations of ease and bind over wider regions.
- **Functional method**, an indirect treatment approach that involves finding the dynamic balance point and one of the following: applying an indirect guiding force, holding the position or adding compression to exaggerate position and allow for spontaneous readjustment. The osteopathic practitioner guides the manipulative procedure while the dysfunctional area is being palpated in order to obtain a continuous feedback of the physiologic response to induced motion. The osteopathic practitioner guides the dysfunctional part so as to create a decreasing sense of tissue resistance (increased compliance).
- **Galbreath treatment**, See *mandibular drainage*.
- **Hepatic pump**, rhythmic compression applied over the liver for purposes of increasing blood flow through the liver and enhancing bile and lymphatic drainage from the liver.
- **Hoover technique**: A form of functional method. Developed by H.V. Hoover, DO. See *functional technique*.
- **High velocity low amplitude (HVLA)**: a direct technique in which a short rapid thrust with little range of motion is applied to bring the joint through a restrictive barrier.
- **Indirect method (I/IND)**, a manual technique where the restrictive barrier is disengaged and the dysfunctional body part is moved away from the restrictive barrier until tissue tension is equal in one or all planes and directions.
- **Inhibitory pressure technique**, the application of steady pressure to soft tissues to reduce reflex activity and produce relaxation.
- **Integrated neuromusculoskeletal release (INR)**, a treatment system in which combined procedures are designed to stretch and reflexly release patterned soft tissue and joint-related restrictions. Both direct and indirect methods are used interactively.

- **Jones technique**, See *counterstrain*.
- **Ligamentous articular strain (LAS)**, 1. A manipulative technique in which the goal of treatment is to balance the tension in opposing ligaments where there is abnormal tension present. 2. A set of myofascial release techniques described by Howard Lippincott, DO, and Rebecca Lippincott, DO. 3. Title of reference work by Conrad Speece, DO, and William Thomas Crow, DO, FAAO. 4. See also *balanced ligamentous techniques*.
- **Liver pump**, See *hepatic pump*
- **Lymphatic pump**, 1. A term used to describe the impact of intrathoracic pressure changes on lymphatic flow. This was the name originally given to the thoracic pump technique before the more extensive physiologic effects of the technique were recognized. 2. A term coined by C. Earl Miller, DO. See *thoracic pump*
- **Lymphatic treatment**, application of oscillation and soft vibrating pressure to the tissue for increasing interstitial lymphatic and lymphatic vessel flow. 2. A second way is described in *veno-lymphatic techniques*.
- **Mandibular drainage technique**, soft tissue manipulative technique using passively induced jaw motion to effect increased drainage of middle ear structures via the eustachian tube and lymphatics.
- **Mesenteric release technique (mesenteric lift)**, technique in which tension is taken off the attachment of the root of the mesentery to the posterior body wall. Simultaneously, the abdominal contents are compressed to enhance venous and lymphatic drainage from the bowel.
- **Muscle energy**, 1. A system of diagnosis and treatment in which the patient voluntarily moves the body as specifically directed by the osteopathic practitioner. This directed patient action is from a precisely controlled position against a defined resistance by the osteopathic practitioner. 2. Refers to a concept first used by Fred L. Mitchell, Sr, DO, originally called muscle energy treatment. 3. Also called postisometric relaxation or myotensive treatment.
- **Myofascial release (MFR)**, a system of diagnosis and treatment first described by Andrew Taylor Still and his early students, which engages continual palpatory feedback to achieve release of myofascial tissues.
- **Direct MFR**, a myofascial tissue restrictive barrier is engaged for the myofascial tissues and the tissue is loaded with a constant force until tissue release occurs.
- **Indirect MFR**, the dysfunctional tissues are guided along the path of least resistance until free movement is achieved.
- **Myofascial technique**, any technique directed at the muscles and fascia. See also *myofascial release*. See also *soft tissue technique*.
- **Myofascial treatment**, See *soft tissue technique*
- **Myotension**, a system of diagnosis and treatment that uses muscular contractions and relaxations under resistance of the osteopathic practitioner to relax, strengthen or stretch muscles, or mobilize joints.
- **Osteopathy in the Cranial Field (OCF)**. 1. A system of diagnosis and treatment by an osteopathic practitioner using the primary respiratory mechanism and balanced membranous tension. See also *primary respiratory mechanism*. 2. Refers to the system of diagnosis and treatment first described by William G. Sutherland, DO. 3. Title of reference work by

Harold Magoun, Sr, DO. 4. Also called *cranial treatment* or *craniosacral treatment* but this might be also used by persons who are not a qualified osteopath.

- **Passive method**, based on techniques in which the patient refrains from voluntary muscle contraction.
- **Pedal pump**, a venous and lymphatic drainage technique applied through the lower extremities; also called the pedal fascial pump or Dalrymple treatment.
- **Percussion vibrator technique**, 1. A manual technique involving the specific application of mechanical vibratory force to treat somatic dysfunction. 2. Developed by Robert Fulford, DO.
- **Positional treatment**, a direct segmental technique in which a combination of leverage, patient ventilatory movements and a fulcrum are used to achieve mobilization of the dysfunctional segment. May be combined with springing or thrust technique.
- **Progressive inhibition of neuromuscular structures (PINS)**, 1. A system of diagnosis and treatment in which the osteopathic practitioner locates two related points and sequentially applies inhibitory pressure along a series of related points. 2. Developed by Dennis Dowling, DO.
- **Range of motion technique**, active or passive movement of a body part to its physiologic or anatomic limit in any or all planes of motion.
- **Slow thrust technique**, 1. Slow direct articular movement with low amplitude after inducing balanced tension of the periarticular tissue. 2. Developed by Kilian Dräger, MD D.O. PhD
- **Soft tissue (ST)**, A system of diagnosis and treatment directed toward tissues other than skeletal or articular elements.
- **soft tissue technique**, a direct technique that usually involves lateral stretching, linear stretching, deep pressure, traction and/or separation of muscle origin and insertion while monitoring tissue response and motion changes by palpation. Also called myofascial treatment.
- **Spencer technique**, a series of direct manual procedures to prevent or decrease soft tissue restrictions about the shoulder. See also *articular treatment (ART)*
- **Splenic pump technique**, rhythmic compression applied over the spleen for the purpose of enhancing the patient's immune response. See also *lymphatic pump*.
- **Spontaneous release by positioning**, See *counterstrain*.
- **Springing technique**, a low velocity/ moderate amplitude technique where the restrictive barrier is engaged repeatedly to produce an increased freedom of motion. See also *articular treatment system*.
- **Still Technique**, 1. Characterized as a specific non-repetitive articular method that is indirect then direct. 2. Attributed to A.T. Still. 3. A term coined by Richard Van Buskirk, DO, PhD.
- **Thoracic pump**, 1. A technique, that consists of intermittent compression of the thoracic cage. 2. Developed by C. Earl Miller, DO 3. See *lymphatic pump*
- **Thrust treatment (HVLA)**, a direct technique that uses high velocity/low amplitude forces. Also called mobilization with impulse treatment.
- **Toggle technique**, short lever technique using compression and shearing

forces.

- **Traction treatment**, a procedure of high or low amplitude in which the parts are stretched or separated along a longitudinal axis with continuous or intermittent force.
- **V-spread**, technique using fluid impulse transmitted across the diameter of the skull to accomplish sutural gapping.
- **Veno-lymphatic techniques**, pumping action via application of rhythmic pressure to local areas of the body or by stretching-compression of more global areas. 2. See also *pedal pump* or *lymphatic treatment*
- **Ventral techniques**, See *visceral treatment*
- **Visceral treatment (VIT)**, a system of diagnosis and treatment directed to the viscera to improve physiologic function. Typically, the viscera are moved toward their fascial attachments to a point of fascial balance. There are three different motions: involuntary movement, inherent movement and respiratory movement. Also called *ventral techniques*.

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