

OIA Educational Forum
16-18 October 2009
Sydney, Australia

Snapshots from around the osteopathic world

Osteopathy is practiced in over than 50 countries under a variety of regulatory frameworks. These are summaries of presentations that were made by representatives from a few of these countries.

Australia – There are approximately 1500 osteopaths in Australia. Five years full time study, award Master in Osteopathy to enter practice. It is the smallest registered health care professional group in the country. It has evolved as a mixture of American and UK education models. State regulation since 1978 is now moving towards federal regulation with the creation of the National osteopathic registration board and accreditation of university programmes. Limited access to Medicare (public health). All major health insurance funds pay a rebate for osteopathic services. Third party, Workers Compensation and Motor Accident insurance all cover osteopathy.

France – French osteopaths currently have imprecise legislation. Two categories of practitioners can use the title osteopath: (1) Those who practice only osteopathy – about 5000 and (2) Those who practice osteopathy and another profession- from physicians to physical therapists – approximately 5000. There are over 40 schools but they are not regulated and many are not of a high quality. Legislative change is slow but the different osteopathic groups are beginning to work more together.

Germany – There are approximately 1000 osteopathic physicians and 2000 osteopaths. Germany has two physician osteopathic groups (DAAO and DGOM) and an osteopath association group (VOD) that are now working together to promote the profession. The VOD is working on establishing a four year BA in osteopathy and a two year masters.

U.K. – Approximately 4000 osteopaths. Allowing GPs to refer to osteopaths has been slow in coming but there is progress. The current focus is on the need for evidence to support osteopathic care and demonstrate competencies vis a vis patient safety. In 2008 the General Osteopathic Council was restructured. There will be a review of statutory regulation in 2011 which will most likely bring additional change. The GOsC and BOA are working in cooperation on strategic issues.

U.S. – Approximately 67,000 DOs that have full physician practice rights. Osteopathic physicians are educated through a four year program plus three or more years of residency training. Accrediting agencies are private but are approved by the Department of Education. The Commission on College Accreditation (COCA) does a comprehensive review of accredited educational institutions once very seven years (with smaller, focused, interim reviews if needed). The standards they use are [available online](#). There is also an Interim Policy Statement on international accreditation. Standards have evolved from proscriptive to more outcome based (core competencies) which creates opportunities for innovation. Licensing is done at the state

level and there are over 70 licensing boards. One in every 5 medical students in the U.S. is an osteopathic student so the profession is still growing quickly.

Education – “3+2?” “Full-time?” - Clive Standen

Clive started his talk about osteopathic education by focusing on the goals and outcomes using an analogy: “Publishing isn’t about books, it’s about reading” and “Education isn’t about educating it’s about osteopathic students treating patients.” He then reviewed educational models that vary from one country to another, but ideally will satisfy basic requirements: (1) Validation: institutional approval of educational quality. (2) Accreditation & Regulation: programme and institution meet criteria for graduate entry to profession; and (3) Quality assurance: ongoing & periodic objective monitoring & review to ensure maintenance of standards.

He noted that in developing and sustaining curricula it is important to keep asking “What do we want to accomplish?” Are courses there to impart knowledge? Develop skills? Provide experience? Impart values? Meet the expectations of others? All of these can be valid but it is important to match the course with the desired outcome vis a vis student practitioners especially in an era where knowledge is increasing so fast that memorization is no longer an effective option. Do our curricula, courses, programmes meet the needs of our students, and their patients?

Clive also presented some additional questions for consideration:

- Do we need to keep students in the same place for 4 or 5 years?
- Can student osteopaths learn in common with students from other professions?
- Do they need to be in the same location as the provider of course content?
- Should we be more interested in thinking than in delivering more “stuff”?
- How long will “Gen Y” put up with traditional modes of delivery?

Finally in summary he noted:

- The current model isn’t sacred
- The environment is changing – government and global agendas are moving on
- Technology is developing
- *Students* are changing – as are their expectations. We are competing for their business.

In the discussion period that followed, Johannes Mayer noted that he has been involved with a survey of students and patients vis a vis outcomes of the students’ education. One of the outcomes was students wanting more problem based training. Evlynnne Gilvarry noted that the UK’s General Osteopathic Council has some patient research vis a vis outcomes and expectations of osteopaths that can be shared. It was also noted that currently hours are used as a guide to competency as it can be monitored but that hours ≠ knowledge and that we need to get better at assessing skills and competency. Finally it was noted that faculty should be used wisely to help students become embedded in the values of the profession.

Managing Complex Osteopathic Organisations – John Crosby

John noted that the AOA –U.S. is a large organization (representing 67,000 osteopathic physicians, with a Board of Trustees of 27 and a staff of approximately 150) but that they try to

approach the organization from an osteopathic perspective. Areas of focus include excellence in membership service, advocacy for the profession in Washington, D.C., accreditation of osteopathic schools, publications and practice management resource.

In a membership organization it is especially important to keep members happy. This is John's list for doing so:

1. Keep core values and mission front and center – for the AOA-US this includes striving to be a great organization G.R.E.A.T – Governance, Research, Education, Advocacy and Teamwork and being a Family of DOs.
2. Make sure core values are understood by all.
3. Encourage intercommunication among all facets of the family.
4. Regular meetings/briefings to keep all informed.
5. Guiding, mediating and stimulating discussion and the organisation's work.
6. Have a strategic plan that is used and reviewed on a regular basis.
7. Drive the organization towards effective outcomes, which equals values to members.
8. Great leadership
9. Great staff

Osteopathic Medicine in the USA: is it really that different? An Australian abroad – Gary Fryer

Gary based his presentation on time that he spent at the A.T. Still University Kirksville College of Osteopathic Medicine in the U.S. He noted that from his observations OMM does not seem to be as central to osteopathic medicine in the U.S. as it is in other parts of the world, and posed the question: If a DO is not actually using OMM how are they distinguished from MDs? He continued by comparing U.S., Australian and British osteopaths vis a vis how much of different modalities they use on a regular basis.

During the discussion period several U.S. DOs mentioned that U.S. schools often take the approach of integrating osteopathic practices and principles throughout the curriculum. It was also noted that although many U.S. DOs do use OMT, the U.S. healthcare environment has disincentives to spending the time that OMT requires. It was also noted that osteopathic practices are not just about techniques.

Raised in open discussion

- The AOA Australia – British Osteopathic Association and Osteopathic Society of New Zealand have developed a strategic liaison Memorandum of Understanding to enhance their communication.
- Boyd Buser shared the results of a patient interaction study that was done in Maine (published by the AOA-U.S.'s Journal) to look at how patient interactions working with osteopathic physicians vis a vis allopathic physicians were different. Over 23 differences were identified, from more discussion of preventive measures to discussing physical health issues in relation to other parts of the patient's life. It was agreed that this was an important study and that more work like this is needed.

- Europe's FORE group has begun to look at osteopathic commonalities among countries in areas such as core competencies, scope of practice and cost effectiveness.
- Areas that could use more cooperative work: (1) Identifying/articulating what makes osteopathy unique; (2) Gathering evidence of osteopathic practice outcomes; (3) Support of emerging national groups and educational programs.

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