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Osteopathy :

a primary healthcare profession

Beroepsvereniging van de Belgische Osteopaten (BVBO) is, the acknowledged professional association for osteopaths in Belgium

1 Introduction

The definition of primary healthcare used in this document is that of 'direct and accessible first line healthcare'.[1] In definitions of 'primary healthcare' around the world,[1,2,3,4] we remember the following characteristics which are perfectly suited to osteopathy: a medical therapy, accessible to everyone; a profession that delivers, and manages preventative healthcare; a field that focusses on helping patient self-management, and encouraging proactive responsibility by patients over their own health.

It is a fact that:

- patients refer themselves to osteopaths in the main for musculoskeletal conditions;[5,6,7]
- musculoskeletal conditions are a significant challenge for the health system: the Université Libre de Bruxelles (ULB) trains 'specialists' precisely for this purpose;[8]
- osteopaths are frequently visited[9] for musculoskeletal conditions and achieve very high patient satisfaction;[10,11]
- according to insurers, there have been no significant insurance claims due to osteopathic care reported in the last decade.

It is self-evident on this basis why the legislator has chosen to include osteopaths in primary care.[12] Implementing the law Colla would mean regulation of a profession that has been active as a first contact primary care profession for 40 years. Osteopaths in fact play a 'first line' (first contact primary care role) not just in Europe,[13] but across world health.[14]

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[1] Samenwerkingsinitiatieven eerstelijnsgezondheidszorg, http://www.vlaamsesels.be/drupal/?q=node/2 (geraadpleegd op 20.10.2015).

[2] Conferentie eertelijnsgezondheidszorg, 11 december 2010, Antwerpen.

[3] http://www.cphcrin-rcrissp.ca/index.php?option=com_content&view=article&id=59:banner-3&catid=12:news&Itemid=6 (geraadpleegd op 20.10.2015).

[4] http://www.phcris.org.au/guides/about_phc.php (geraadpleegd op 20.10.2015).

[5] van Dun P.L.S. *Status van de Osteopathie in de Benelux: Benelux Osteosurvey 2013*, Mechelen, Commission for Osteopathic Research, Practice and Promotion vzw (CORPP vzw), DOI: 10.13140/RG.2.1.3665.1367
http://www.corpp.org/sites/default/files/global/pages/Benelux_Osteosurvey_2013.pdf

[6] De Gendt T, Desomer A, Goossens M, Hanquet G, Léonard C, Mélard F, Mertens R, Piérart J, Robays J, Schmitz O, Vinck I, Kohn L. *Stand van zaken voor de osteopathie en de chiropraxie in België.* Health Services Research (HSR). Brussel: Federaal Kenniscentrum voor de Gezondheidszorg (KCE). 2010. KCE Reports 148A. D/2010/10.273/91.

[7] Fawkes C., Leach J., Mathias S., Moore A., *The Standardised Data Collection Project – Standardised data collection within osteopathic practice in the UK: development and first use of a tool to profile osteopathic care in 2009*. London, National Council for Osteopathic Research (NCOR), June 2010 http://www.osteopathy.org.uk/uploads/standardised_data_collection_finalreport_24062010.pdf

[8] https://www.ulb.ac.be/facs/fsm/secrt-osteo.html

[9] Drieskens S. Contacten met beoefenaars van niet-conventionele geneeswijzen. In: Drieskens S, Gisle L (ed.). Gezondheidsenquête 2013. Rapport 3: Gebruik van gezondheids- en welzijnsdiensten. WIV-ISP, Brussel, 2015

[10] Nauwelaers, I.; Sermeus, G. In handen van de osteopaat. *Test gezondheid,* nr. 52. Brussel: Verbruikersunie, 2003.

[11] Delterne, E.; Sermeus, G. Enquête: alternatieve geneeswijzen. *Test gezondheid,* nr. 81. Brussel: Verbruikersunie, 2007.

[12] Wet-Colla van 29 april 1999, Art.9 §2

[13] CEN/TC 414 - Project Committee - *Services in Osteopathy, Osteopathic healthcare provision*, 2014, draft presented for formal vote.

[14] Osteopathic International Alliance (OIA), *Osteopathy and Osteopathic Medicine: A Global View of Practice, Patients, Education and the Contribution to Healthcare Delivery*, 2013, Chicago.

Nonetheless, there are still policymakers who challenge the first line role for osteopaths. This is mainly based on inadequate or sometimes erroneous information about the osteopathic profession, and an unfounded fear that the central role of the general practitioner in primary care would somehow be eroded. This situation means that some policymakers hold tightly to regulations that are no longer relevant. In doing this they are rejecting, possibly unconsciously, the principle of evidence-based medicine. A principle that was rightly included in the federal coalition agreement of October 2014, on which health policy would be coordinated.

This document aims to inform and legitimise in an objective and substantiated manner why the professional group of Belgian osteopaths thinks that the first line function for the osteopath is justified.

To this end, reference is made in this document to evidence based research, and best practice as well as clinical case histories. The latter illustrate what osteopaths do in their daily practice and what the consequences may be for their patients.

2 Existing legal framework

In the context of the background to the current situation, the parliamentry preparation of the Law of 19 April 1999 *on the unconventional practices in medicine, pharmacy, physiotherapy, medicine nursing and the paramedical professions* (hereafter: the 'Colla Law') the legislator has made a conscious choice in 1999 to place osteopaths in primary care.

Even despite the fact that the legislator has not taken into account the role of osteopaths in clinical diagnosis, there are many provisions in the Colla law that should provide policy makers with sufficient guarantees to confirm the first line function with confidence.

For example, the osteopath is legally obliged when a patient who presents him or herself to him to request the submission of *'a recent diagnosis concerning his complaint [...] drawn up in writing by a physician of your choice*'. (Article 9 § 2 Colla Law).

If the patient cannot present such a recent diagnosis, the osteopath may proceed to treat a patient who knows in an informed manner and in an unambiguous way that he does not wish to consult a physician of his choice before treatment by the osteopath concerned, and the patient also confirms this wish in writing (Article 9 § 2 Colla Law).

It goes without saying that if the osteopath has doubts about the extent to which a patient has the required *'knowledge of the matter'* and thus there is *'informed consent'*, he or she should ideally refer the patient concerned to a general practitioner for diagnosis. After all, if an osteopath starts treatment (even from negligence) without the submission of a recent diagnosis or the quoted written statement he or she exposes him or herself to criminal fines (Article 11 § 2 Colla Law).

Of course, in both hypotheses it is assumed that the osteopath stays meticulously inside his or her professional competence profile[15] such as defined among others in the K2 Advice from the Chamber of Osteopathy of 11 September 2012 concerning the definition of osteopathy.

Furthermore, the osteopath must – in line with other care professions – have a file for each of his patients in order to keep track of either the recent diagnosis of a physician or the statement of the

[15] van Dun P.L.S, Beroepscompetentieprofiel Osteopathie, 2010, Brussel: Groepering Nationaal en Representatief van de Professionele Osteopaten vzw (GNRPO vzw), DOI: 10.13140/RG.2.1.2354.4162
http://www.sbo-bvo.be/sites/default/files/global/pages/Documenten/Politics/Profil/BCP_Osteopathie_GNRPO.pdf

patient (Article 9 § 1 Colla Law) and he or she is subject to the same, criminal law sanctioned, professional confidentiality as physicians (Article 458 Penal Code - Article 9 § 3 Colla Law).

In addition, the osteopath must '*take every precaution to prevent the patient from having a conventional treatment denied*' (Article. 9 § 3 Colla Law).

Thus the osteopath is legally obliged '*to provide a physician with information at his request about the development of the health status of his patient.*' In fact, *'in the interest of the patient, each physician can also on his own initiative seek information [of the osteopath] about the development of the health of his patient*'. (Article 9 § 3 Colla Law).

This flow of information applies not only to a physician but equally towards other osteopaths. This information is only provided on condition that the patient or the person legally authorised to consent on his behalf to a medical act, agrees to this (Article 9 § 3 Colla Law).

Naturally, the osteopath must make a trade-off between his duty of care, as a patient cannot be *'denied conventional treatment',* and the possible refusal of the patient concerned to let information be communicated to a physician.
We should bear in mind that the documents referred to in the Colla law or in the implementing decisions in electronic version may already be submitted as far as this evidential value is concerned in accordance with Article 36/1, § 1, of the Law of 21 August 2008 *establishment and organisation of the eHealth-platform and various provisions* (Article 8/1 of the Colla Law).

It is recommended that this information exchange is included in the Global Medical File (GMD). Such obligations are already in place as article 10 § 2 of the Colla Law creates the possibility of one or more provisions of Royal Decree No. 78 of 10 November 1967 *concerning the practice of medicine, the paramedical professions and the medical committees*[16] to declare applicable to osteopaths.

3 Objective grounds for a first contact primary care role of the osteopath

In addition to the Law of 29 April 1999, several legal and/or scientifically relevant arguments can be cited to legitimise the proper functioning of an osteopath within his professional competences in primary healthcare.

3.1 The training for osteopath

In the first place, it was agreed in the Chamber of Osteopathy that osteopaths should have a Master of Science (MSc) degree in osteopathy in order to be admitted to the profession.[17]
The length of training is at least 5 years, which corresponds to 300 ECTS. After all, the master's programme aims to bring students to an advanced level of knowledge and competences specific to scientific functioning in general and to a specific domain of sciences (*in this case*: *osteopathy*) in particular. This level of education is necessary for the autonomous practice of science or for the use of this scientific knowledge in the independent exercise of a profession. Master's programmes are intrinsically academically oriented, but can also have a professional orientation such as those for

[16] Thans de gecoördineerde wet van 15 mei 2015 betreffende de uitoefening van de gezondheidsberoepen.

[17] Advies K3 van de Kamer voor Osteopathie van 12 juni 2012 *betreffende het opleidingsniveau om het vereiste profiel in de osteopathie te behalen.* http://health.belgium.be/internet2Prd/groups/public/@public/@dg2/@healthprofessions/documents/ie2divers/19083674.pdf

physicians, physiotherapists and psychologists. The first line role of the osteopath thus fully aligns with the same principle.

The only regular, subsidised training for osteopaths in Belgium is a six year university program at the ULB (360 ECTS), where the graduates have a masters in motor science and a masters in clinical osteopathy. This training is delivered by the faculty of motor sciences (*Motricité*) in close cooperation with the faculty of medicine.

3.2 In accordance with the definition

In line with the agreed description of osteopathy in the Chamber of Oteopathy,[18] the case for primary care focusses on pathologies and dysfunctions of the locomotor system (i.e. musculoskeletal system) and the peripheral nervous system.

Research shows that most patients consult an osteopath for musculoskeletal complaints and more specifically for vertebral column complaints of mainly the neck and the lower back. More specifically, low back pain, neck complaints, cervicobrachialgia and headache/migraine appear to be the four most common reasons for osteopathic consultation in Belgium. [19]

Musculoskeletal pain is common in all populations and has a significant financial impact on the individual patient, and society in general. Disorders of the musculoskeletal system have always been one of the most frequently reported occupational diseases [20] and are the second most frequent reason for consulting a family physician.[21] In the United Kingdom, in the period 2008-2009, an estimated 9.3 million working days were lost due to these disorders.[22] In Denmark, a quarter of all health-related invalidity pensions are awarded as a result of disorders of the musculoskeletal system, and notably, an average of seven years poorer quality of life due to musculoskeletal-related pain and disability.[23]

The rising life expectancy together with the associated increase in the number of elderly in our society, will also increase the impact of these problems and the demand for care for these musculoskeletal complaints.[24,25]

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[18] Advies K2 van de Kamer voor Osteopathie van 11 september 2012 betreffende *de definitie van osteopathie conform aan de wet van 29 april 1999 betreffende de niet-conventionele praktijken inzake de geneeskunde, de artsenijbereidkunde, de kinesitherapie, de verpleegkunde en de paramedische beroepen.*
http://health.belgium.be/internet2Prd/groups/public/@public/@dg2/@healthprofessions/documents/ie2divers/19083665_fr.pdf

[19] Ibid.

[20] Vos, T., Flaxman, et al., Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990 2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet,* 2012, *380*(9859), 2163-2196. doi:10.1016/S0140-6736(12)61729-2.

[21] Department of Health: The Musculoskeletal Services Framework - A Joint Responsibility: Doing it Differently. London: Department of Health; July 2006.

[22] Health and Safety Executive: Musculoskeletal disorders (MSDs) in Great Britain (GB)
http://www.hse.gov.uk/statistics/causdis/musculoskeletal/index.htm

[23] Kjøller M, Kamper-Jørgensen F (Eds): *Public Health Report, Denmark 2007 [in Danish]*. Copenhagen: Danish National Institute of Public Health, University of Southern Denmark; 2007

[24] Ibid.

[25] Smith, E., Hoy, D. G., Cross, M., Vos, T., Naghavi, M., Buchbinder, R., Woolf A.D., March, L. The global burden of other musculoskeletal disorders: estimates from the Global Burden of Disease 2010 study. *Ann Rheum Dis,* 2014, 73(8): 1462-1469. doi:10.1136/annrheumdis-2013-204680.

Foster et al.[26] conclude that, in the context of the social burden with regard to musculoskeletal disorders and recent research results concerning the best care for these patients, there are strong reasons to extend the first contact care role to other professional groups, such as osteopathy.

3.3 A better care for patients with musculoskeletal complaints

Research shows that the primary care of many musculoskeletal complaints appears to be quite a challenge for many general practitioners, who are not adequately trained when it comes to 'function', 'movement', 'activity', etc. In addition, patients often do not feel their complaints are taken seriously and are regularly sent home with the message: 'nothing can be done about this' or 'you have to learn to live with that'.[27, 28] Even the knowledge and skills of emergency physicians in relation to musculoskeletal complaints show serious shortcomings.[29]

> W.S., 52 years old, goes to her general practitioner for consultation after a fall from her horse. Patient complains about pain in the chest area that radiates to the left and a short period of breathlessness after the fall. The general practitioner examines the patient at the level of the vertebral column but the test results do not seem conclusive and sends Mrs. W.S. home with the reassuring words that it is muscle cramp, and he prescribes an inflammatory inhibitor. A week later, and in the event of persistent complaints, Mrs. W.S. consults her osteopath, who after an extensive clinical examination identifies some positive tests and refers the patient to the radiology department. Mrs. W.S. returns home after radiological examination with the diagnosis of two thoracic vertebrae and four rib fractures.
>
> *Clarification: even though it was not a typical clinical case, both for the general practitioner and for the osteopath, the osteopath's expertise in musculoskeletal disorders gives the osteopath better clinical insight into the situation. This may lead to a better differential diagnosis. It is good that the osteopath perceives its first line role and may not administer the wrong care in the second line.*
> *Osteopathy students from the ULB who do an internship in an emergency department are praised for their diagnostic capacities, and perform a first screening there, after which they refer to other services such as orthopaedics, neurology, and radiology.*

Several high-quality intervention studies show that non-pharmacological care, as well manual medicine, can deliver better results than the primary care provided by the general practitioner.[30]
A broader provision of first contact options for patients with musculoskeletal complaints improves the freedom of choice of the patient[31] and also ensures better and faster care. This is not unimportant

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[26] Foster N.E., Hartvigsen J., Croft P.R. Taking responsibility for the early assessment and treatment of patients with musculoskeletal pain: a review and critical analysis, *Arthritis Research & Therapy,* 2012, 14: 205. http://arthritis-research.com/content/14/1/205

[27] Ibid.

[28] Alami S, Boutron I, Desjeux D, Hirschhorn M, Meric G, Rannou F, Poiraudeau S: Patients' and practitioners' views of knee osteoarthritis and its management: a qualitative interview study, *PLoS One*; 2011, 6: e19634
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0019634

[29] Comer G.C., Liang E., Bishop J.A.: Lack of Proficiency in Musculoskeletal Medicine Amongst Emergency Medicine Physicians, *J. Orthop. Trauma*; 2013, doi: 10.1097/BOT.0b013e3182a66829

[30] Foster NE, Dziedzic KS, van der Windt DA, Fritz JM, Hay EM: Research priorities for non-pharmacological therapies for common musculoskeletal problems: nationally and internationally agreed recommendations, *BMC Musculoskelet Disord* 2009, 10: 3
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2631495/?tool=pubmed

[31] Wet op de patiëntenrechten van 2002.

when taking into account the expected increased burden of musculoskeletal complaints over the next 50 years as a result of the aging population. This means that the current care model has to be adapted to meet the increased demand.[32]

This reorganisation of the primary care model has generated the expected resistance in conventional medicine, and is partly due to a lack of understanding, but it should be appreciated that this service transformation will also benefit the general practitioner.[33] A direct access for musculoskeletal and functional disorders for the osteopath can clearly decrease the workload for the general practitioner.

Research also shows that the general practitioner, both in his medical training and in his internship and postgraduate education, is insufficiently trained in musculoskeletal complaints and has insufficient knowledge concerning non-pharmacological treatment options for the patient.[34] Surveys and interviews of the general practitioner population also show that they lack confidence and do not feel well equipped to handle these complaints.[35,36,37] This is in stark contrast to the knowledge and skills of the osteopath to examine and treat these patients. Osteopaths also seem well prepared for these functions.[38]

> F.D., 51 years old, regularly works with a heavy drilling machine and has been struggling for 6 weeks with a painful right shoulder. After two weeks with painkillers at work and a more and more limited functionality, his wife makes an appointment for him with her osteopath. After a detailed history taking and clinical examination, the osteopath advises Mr. F.D. to do a neurological examination, in particular an electromyogram (EMG) of the thoracic nerve longus. This to exclude the suspicion of a nerve paralysis. The neurologist is initially suspicious regarding this very specific demand but is ultimately surprised with the result of the EMG that actually shows a paralysis of precisely the aforementioned nerve.
>
> Mrs. S.E., 62 years old, is desperate when she comes to consult with an osteopath. The 'restriction of movement' in her shoulder seriously disturbs her in her daily activities and there seems to come no improvement after a two-year Odyssey of treatments (anti-inflammatory, physiotherapy, injections with cortisone and finally an operation in which bone from the shoulder roof was milled away and the bursa was removed). The osteopath is her last hope. The osteopath determines that there is no question of an impingement syndrome (a condition in which all of the foregoing treatments were based) but that nerve paralysis is the cause of her restriction of movement. A diagnosis that is experienced by Mrs. S.E. through performing a simple test by the osteopath and which is later confirmed by a neurological consultation with EMG examination.

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[32] Hartvigsen J, Christensen K: Back and neck pain are with us till the end. A nationwide interview-based survey of Danish 100-year olds, *Spine* 2008, 33: 909-913.

[33] Breen A, Austin H, Campion-Smith C, Carr E, Mann E: 'You feel so hopeless': a qualitative study of GP management of acute back pain, *Eur J Pain;* 2007, 11: 21-29.

[34] Chehade MJ, Burgess TA, Bentley DJ: Ensuring quality of care through implementation of a competency based musculoskeletal education framework, *Arthritis Care Res (Hoboken);* 2011, 63: 58-64. http://onlinelibrary.wiley.com/store/10.1002/acr.20329/asset/20329_ftp.pdf?v=1&t=heo29hhy&s=276273e6d7d47a38d44c39c25f34118f9070e11d&systemMessage=Pay+Per+View+will+be+unavailable+for+upto+3+hours+from+06%3A00+EST+March+23rd+on+Wiley+Online+Library.+We+apologise+for+the+inconvenience

[35] Lønnberg F: The management of back problems among the population. I. Contact patterns and therapeutic routines [in Danish], *Ugeskr Laeger,* 1997, 159: 2207-2214.

[36] Ibid.

[37] Ibid.

[38] Luciani E, van Dun PLS, Esteves JE, Lunghi C, Petracca M, Papa L, et al. (2015) Learning Environment, Preparedness and Satisfaction in Osteopathy in Europe: The PreSS Study. PLoS ONE 10(6): e0129904. doi:10.1371/journal.pone.0129904

Explanation: the same pathology (Parsonage-Turner Syndrome) in two different cases but with two completely different courses of action. This not only means the 'course of disease' in itself, but a course that makes the difference on all fronts, not at least for the patient.

In addition, the research and academic development related to musculoskeletal and functional disorders is actually carried out by e.g. osteopaths, and is being ignored by the academic world of general practitioners, despite an ever increasing importance to clinical practice. This means significant new knowledge about diagnosis and treatment of musculoskeletal complaints is generated by (amongst others) osteopaths and not by general practitioners.

It is clear that assigning a first contact primary care role to osteopaths has advantages for both the patient and the general practitioner.

The current evidence provides sufficient cause to assume that a model, where the first contact primary care role in musculoskeletal disorders[39] can be delivered by osteopaths, will be as safe and effective as the current general practitioner-led model, and provides us with sufficient reasons to assume that it can sustain a more appropriate, efficient and effective care for most primary care recipients with musculoskeletal disorders.[40]

3.4 Safe care

Despite the good education of the osteopath and the tightly defined care they offer, there remain questions about whether an osteopath can offer a sufficiently safe care concerning the recognition of serious pathologies and/or the frequent occurrence of more than one (chronic) illness with one individual during a certain period (multimorbidity).

> Mrs. E.M., 26 years old, consults an osteopath for headaches who have been occurring more frequently in the last few weeks and does not really respond to the medication that she receives from her general practitioner. In the anamnesis she also mentions an irregular menstruation since a year and is initially treated hormonally but is completely absent after about 6 months (amenorrhea). Because the patient does intensive sport and experiences this more as a blessing, no further attention is spent here.
> Nevertheless, the osteopath recommends a blood test, because both the anamnesis as well as the clinical examination suggest no mechanical cause of the headaches, and a hormonal cause should be considered. After lengthy urging to the general practitioner, this examination is finally performed and what was immediately remarkable was the increased cortisol level. The general practitioner, who does not see a connection between the amenorrhoea and the elevated cortisol level, prescribes a stronger hormone preparation, and advises his patient to exercise less intensively.
> Meanwhile, the osteopath, after the third consultation with the patient, notices some physical changes with Mrs.E.M., which pushes a Cushing syndrome image (a hormonal disorder) more and more on the foreground and he requests his patient for an urgent radiological consultation of the head, particularly because the headaches are getting worse and he wants to exclude a pituitary tumour. This request is made twice by the osteopath, but is refused by the general practitioner and the hospital respectively. Until the patient finally seeks help, under guidance

[39] Ibid.

[40] Ibid.

of her osteopath, at a university hospital where the necessary examinations are carried out. Exactly one week later the patient is operated on a pituitary tumour.

Explanation: this disconcerting example not only shows that the osteopath takes its diagnostic function very seriously and fulfils it satisfactorily. It also shows that an inter-collegial collaboration with mutual respect is necessary in the interest of the patient.
In a survey of the Benelux osteopaths in 2013, 'the wish for better cooperation with other health professions (respect, trust, acceptance and multidisciplinary work)' stands second on the wish list of 'the most ideal development of osteopathy', after the wish of 'the profession of osteopath as an independent, autonomous primary care medicine'.

Recognition of severe musculoskeletal pathologies

Despite the fact that the osteopath has received a solid education and is therefore educated to conduct a differential diagnosis with knowledge (K2, 11.09.2012), research shows that serious pathologies rarely (0.9%) occur with these types of complaints.[41]

There is even evidence that a too great focus on differential diagnosis and red flags distracts the general practitioner from an evidence based practice (EBP) and thus contributes to unnecessary research, overmedication and increased incapacity for work and costs.[42] Also the quality of the diagnosis of certain musculoskeletal disorders performed by the general practitioner are being questioned.[43,44]

Research shows that there is no evidence that general practitioners are better than, for example, osteopaths in recognition of serious pathologies. Rather, no difference can be made with regard to the correctness of the diagnosis of musculoskeletal disorders between general practitioners and, for example, osteopaths.[45]

Complexity and multimorbidity

It is a fact that most consultations in the first line relate to people with multimorbidity (78%)[46] and that these patients are therefore more complex in their diagnosis and treatment.
These facts require a broad approach to the patient in question, in which case one generally thinks of the general practitioner. For the patient with multiple health problems, who himself gives priority to

[41] Henschke N, Maher CG, Refshauge KM, Herbert RD, Cumming RG, Bleasel J, York J, Das A, McAuley JH: Prevalence of and screening for serious spinal pathology in patients presenting to primary care settings with acute low back pain, *Arthritis Rheum* 2009, 60: 3072-3080 http://onlinelibrary.wiley.com/store/10.1002/art.24853/asset/24853_ftp.pdf?v=1&t=hek2dnw2&s=8a656af20f7fe62719872acaca7ecccf35e4db17

[42] Williams CM, Maher CG, Hancock MJ, McAuley JH, McLachlan AJ, Britt H, Fahridin S, Harrison C, Latimer J: Low back pain and best practice care: a survey of general practice physicians, *Arch Intern Med* 2010, 170:271-277 http://archinte.jamanetwork.com/article.aspx?articleid=415588

[43] Roddy E, Zhang W, Doherty M: Concordance of the management of chronic gout in a UK primary-care population with the EULAR gout recommendations, *Ann Rheum Dis* 2007, 66:1311-1315 http://ard.bmj.com/content/66/10/1311.long

[44] Robinson PC, Taylor WJ: Time to treatment in rheumatoid arthritis: factors associated with time to treatment initiation and urgent triage assessment of general practitioner referrals, *J Clin Rheumatol* 2010, 16:267-273

[45] Patel S, Hossain FS, Colaco HB, El-Husseiny M, Lee MH: The accuracy of primary care teams in diagnosing disorders of the shoulder, *J Eval Clin Pract* 2011, 17:118-122

[46] Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA: Epidemiology and impact of multimorbidity in primary care: a retrospective cohort study, *Br J Gen Pract;* 2011, 61: 12-21

his musculoskeletal complaints, there are indications that the general practitioner mainly will give priority to health problems other than musculoskeletal complaints.[47]

The osteopath is properly trained for this complexity and multimorbidity and it is no secret that the focus on the complex interplay of the different structures and functions in the body is one of the identity characteristics of osteopathy. The multidisciplinary collaboration with other care professions has been elaborated as a role in the professional competence profile.[48]

3.5 Cost effectiveness

Furthermore, it was shown that the usual care for patients with low back pain by general practitioners, on average does not correspond to those prescribed in the international evidence based guidelines.[49] People still prefer expensive care strategies, such as medication and medical care imaging, rather than the more recommended care such as osteopathy[50] as a manual medicine, which in addition is closely linked to the expectations of the patient and shows a very high level of general satisfaction.[51] Osteopathic care is also always recommended in clinical guidelines.[52,53,54]

Cost-effectiveness studies of randomised clinical intervention studies show that the primary care for patients with low back pain is not cost-effective unless combined with, for example, spinal manipulations.[55] With regard to osteopathic care as a total package, and not only with regard to a sub-aspect of it, such as spinal manipulations, there is still a lot of work yet to be done and the profession knows the need to meet this.[56,57] In current clinical intervention studies attention is already paid to

[47] Lugtenberg M, Zegers-van Schaick JM, Westert GP, Burgers JS: Why don't physicians adhere to guideline recommendations in practice? An analysis of barriers among Dutch general practitioners, *Implement Sci* 2009, 4: 54 http://www.implementationscience.com/content/4/1/54

[48] Ibid.

[49] Foster, N. E. et al. Prevention and treatment of low back pain: evidence, challenges, and promising directions. *The Lancet* (21st March 2018), http:// dx.doi.org/10.1016/S0140-6736(18)30489-6.

[50] Williams CM, Maher CG, Hancock MJ, McAuley JH, McLachlan AJ, Britt H, Fahridin S, Harrison C, Latimer J: Low back pain and best practice care: a survey of general practice physicians, *Arch Intern Med* 2010, 170: 271-277 http://archinte.jamanetwork.com/article.aspx?articleid=415588

[51] Xue CC, Zhang AL, Lin V, Myers R, Polus B, Story DF: Acupuncture, chiropractic and osteopathy use in Australia: a national population survey, *BMC Public Health* 2008, 8: 105. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2322980/?tool=pubmed

[52] National Institute for Health and Clinical Excellence, 2011. http://www.nice.org.uk/guidance/cg88/evidence

[53] Koes B.W., Van Tulder M., Lin C.W., Macedo L.G., Mcauley J., Maher C.: An updated overview of clinical guidelines for the management of non-specific low back pain in primary care. In: *Eur Spine J.,* 2010, Dec. 19(12): 2075-94.

[54] American Osteopathic Association. American Osteopathic Association guidelines for osteopathic manipulative treatment (OMT) for patients with low back pain. Chicago (IL): American Osteopathic Association; 2009. http://www.osteopathic.org/inside-aoa/development/quality/Documents/aoa-guidelines-for-omt-for-patients-with-low-back-pain.pdf

[55] Lin CW, Haas M, Maher CG, Machado LA, van Tulder MW: Cost-effectiveness of general practice care for low back pain: a systematic review, *Eur Spine J;* 2011, 20: 1012-1023. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3176699/?tool=pubmed

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this and the early results are really positive.[58,59] To meet the demand for the cost-effectiveness of osteopathic care, Belgian osteopathic associations have been working since 2016 on the Health Economic Value for Osteopathy project (HEVO-project). In the first phase, this cost analysis shows that osteopathic care for neck pain in Belgium is cost-effective and for low back pain even cost-saving.[60]

3.6 Prevention

The elaboration of health objectives related to prevention is one of the ten pillars of the recovery plan for Belgian health care proposed by health economist Annemans.[61]

Preventative medicine is about promoting health, maintaining health, preventing the occurrence of diseases, preventing the progression of diseases and preventing chronic diseases.

The preventative function of osteopathy is determined by the osteopathic view of disease and health as gradual phenomena. This vision leads to a form of prevention that differs from conventional medicine (such as vaccination and screening programs). The osteopathic view of the organism as an ingenious mechanism constitutes the fundamental legitimation for the approach. This is namely the restoration of the body's mechanism by mechanically intervening, manually and without additions, because what is needed is present in the organism itself. Osteopathic intervention, thus acts on the self-healing and self-regulating abilities of the body. Osteopathy has in this issue the argument that it is cheap, precisely because it is a non-instrumental, non-drug therapy. Moreover, the osteopathic vision can add an important aspect to the social thinking about illness and health, because she takes her starting point in the potential for health in the organism. She can thus play a role in promoting confidence in and the possibility of health.[62]

3.7 Primum non nocere

In healthcare this is an important ethical principle which also applies to osteopathy. Certain diagnostic as well as therapeutic techniques can, like all medical acts for that matter, carry a certain risk. The conditions for weighing up the beneficial effect of an intervention against the possible side effects, and in this way, to fully comply with the aforementioned rule, is a sound medical training but above all a moral and legal responsibility of its practitioners.

As it is difficult to imagine that a general practitioner wants to assume the responsibility of a surgical intervention or an action performed by the dentist, even if advised by him, this is also impossible for an osteopathic consultation. Osteopathy that requires a six-year university degree presupposes a unique knowledge and skill that only an osteopath possesses and therefore cannot be prescribed.

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4 Conclusion

The osteopathic profession in Belgium considers the last 40 years of working de facto as a first contact primary care profession, as an earned right of passage. A right that was recognised more than 19 years ago in the Colla law, which should nowadays no longer form a matter for debate. The osteopathic profession has, despite the virtually non-existent resources and the poor support received, increasingly built a well organised profession with a university degree and has collaborated constructively in the Chamber of Osteopathy and beyond.

Based on the effectiveness of the osteopathic care, the patient satisfaction and the cooperation on the ground with other health professions, the position of the osteopath as a first contact care profession can be properly considered as a valuable asset to the nation's health. The profession of the Belgian osteopaths therefore urgently ask the policy makers concerned to acknowledge this social and scientific reality and promptly confirm the primary position of osteopathy, as a manual medicine,[63] in health care.

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BVBO
Charles Madoux laan, 59
1160 Brussel (Audergem)
Tel: + 32 2 512 35 89
www.osteopathie.be

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