NORDIC OSTEOPATHIC JOURNAL

NORSK OSTEOPATFORBUND

Svenska Osteopatförbundet

Suomen Osteopaattiliitto ry · Finlands Osteopatförbund rf

Danske Osteopater

OSTEÓPATÍA
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Redaktørens hjørne

Kjære lesere!

For første gang i historien utgir vi en nordisk utgave av Osteopaten. Målet er at vi én gang i året (siste utgave) vil ha denne formen og at dette vil være et samarbeid mellom de ulike nasjonene. Utviklingen av Osteopaten i Norge har vært stigende, og avhengig av mange bidragsytere og dugnadsarbeidere. Det er lagt mange timer bak for å kunne mate medlemmene med artikler, intervjuer og annen informasjon.

I flere år har vi klart å opprettholde å gi ut fire blader i året, hvor vi nå har en visjon å gjøre om den ene utgaven til å bli Nordic Osteopathic journal. Ønsket er å bringe nasjonene nærmere hverandre, og til og med kanskje en gang i fremtiden, kunne bli et litt mer anerkjent medlemsblad for andre profesjoner også.

I bladet foran dere, vil dere finne en rekke artikler og innlegg hvor alle de nordiske nasjonene har alle hatt sitt bidrag. Takket være engasjerte ledere og medlemmer, kan vi nå med stolthet presentere dette bladet. Veien blir til som vi går og jeg gleder meg over å kunne være en del av det.

Ikke nøl med å ta kontakt med meg dersom du har noe spørsmål eller kommentarer.

Mvh
Ingrid Nicander
Osteopat og redaktør
ingrid@nicander.no

Sjefen har ordet

Kjære medlemmer,

I hånden holder du nå den aller første utgaven av Nordic Osteopathic Journal (NOJ), og jeg håper at du liker det du ser! En spesiell takk til redaktør som denne gangen fikk en stor oppgave i fanget – og har løst den utmerket. Takk også til de mange norske bidragsyterne, her er vi er godt representert med artikler. Målet var å skape et lettlestmagasin med en fin miks av faglig tyngde og refleksjoner. Bladet er et konkret resultat av vårt gode nordiske samarbeid, og den tette dialog vi har mellom forbundene. Vi står sterkere sammen, noe avstemmingen i Nordisk Råd viste tydelig. En felles strategi, god samhandling og direkte kontakt med sentrale politikere gjorde en forskjell. Jeg og styret i NOF setter stor pris på vårt nordiske samarbeid.

Avstemmingen i Nordisk Råd var viktig for oss da den gav en indikasjon på det politiske landskapet i Norden inkludert Norge. Resultatet er dog ikke gitt da dette handler om en oppfordring til den norske regjeringen om å regulere osteopati, uten å være bindende.

De fleste har fått med seg at Helsedirektoratet (HDIR) på oppdrag av Helse og Omsorgs-departementet (HOD) bearbeidet vår søknad om autorisasjon, sendt til HOD i Desember 2018. HDIR sin innstilling ble oversendt til oss i midten av November 2019, og vi har frist til midten av Januar 2020 med å komme med våre kommentarer. Det er HOD og politisk ledelse som til syvende og sist avgjør om vi når frem eller ikke. HDIR sin innstilling er ikke udelt negativ. De løfter frem flere gode grunner for at vi bør autoriseres, men også noe de mener trekker ned. Vi mener at de ikke satt seg grundig nok inn i vår yrkesrolle og det vi presentert av fundament for en trygg og kunnskapsbasert osteopatisk helsetjeneste. Vi skal bruke tiden frem til midten av Januar godt. Autoteamet jobber svært dedikert med vårt tilsvar. Om vi når helt frem er vanskelig å si, men vi skal gjøre vårt beste. Parallelt med dette fortsetter vi vår strategi om å være synlige og tilstede i medie-bildet, i tillegg til direkte politisk kontakt.

Helseforsikringer har vi hatt mange runder med, også i senere tid. Vi har kommet tettere på de store selskapene og er i en dialog. Jeg tror vi må ta innover oss at dette handler om markedskrefter det er vanskelig for oss å få sterk kontroll over. Selskapene prøver opplagt å få mest mulig for minst mulig, og det er flere aktører som alle vi ha sin del av kaken. Vi skal dog fortsette å formidle at vi leverer kvalitet og at de ved å henvise sine pasienter til oss skal være trygge på at de får god og riktig kartlegging, vurdering og behandling. Jeg tror ikke at det er lurt av oss å kutte på kvalitet ved å f.eks. gi kortere timer eller på andre måter forenkle tjenesten. Hver og en må ta et valg på om man ønsker å inngå avtale eller ikke ut fra de rammer som tilbys. Er man med så leveres kvalitet. Vi er alle enige om at en kvalitativt god helsetjeneste må tilbys økonomiske rammer som er forenlig med å drive en praksis.

I tiden fremover kommer det flere gode faglige aktiviteter i regi av NOF. I løpet av våren blir det blant annet fagdag på Lerkendal, fagdag i Oslo med årsmøte og flere kurs. Senere i 2020 er det Nordisk konferanse i Finland, og enda flere kurs. Følg med og møt opp! I tillegg til faglig påfyll er det alltid hyggelig å møte kolleger og kanskje knytte noen nye kontakter.

Jeg ønsker dere alle en riktig God Jul og Godt Nytt År, og vil samtidig takke for tilliten til å lede NOF i disse spennende tider!

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NORSK
OSTEOPATFORBUND

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Nordic Osteopathic Alliance

Haraldur Magnússon

President of the Icelandic Osteopathic assosiation

Regulated since 2005, protected title and fully licensed health professional.

Number of members: 3 and a few more pending

Laura Lee Kamppila

President of the Finnish Osteopathic assosiation

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Regulated since 1994
Number of members: 178
Student members: 33

Tomas Collin

President of the Norwegian Osteopathic assosiation

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Number of members: 420

Gudrun Göransson

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Number of members: 281
Student members 83

Hanna Tómasdóttir

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Authorised since: 1. July 2018
Number of members: 201

Follow "Nordic Osteopathic Alliance" on Facebook to keep updated

nordic_osteopathic_alliance

Dear colleagues

It is with great pleasure and honour that we, the five Nordic Presidents, hereby present the very first Nordic Osteopathic Journal (NOJ). The aim of NOJ is to share relevant news regarding the standing of the osteopathic profession and to raise the awareness of what osteopathy can bring to modern health care in the Nordic region. The journey began several years ago with Nordic "small talk" and sharing our dreams and visions, during meetings in the European context.

Our co-operation was initiated officially this year in Copenhagen, when Danske Osteopater hosted the very first Presidential Meeting on January 11th. At this meeting we were invited to the Danish Parliament, Folketinget. Helge, Gudrun, Laura and Hanna had a great meeting with Liselott Blixt, MP and Chair of the Danish Health Commission. Liselott encouraged us to put forward a missive for a common framework for authorization of osteopathy in all Nordic countries, as this would put pressure on the Norwegian and Swedish government.
The missive was delivered in January 2019 and later accepted by the Nordic Council, the official body for inter-parliamentary co-operation between all the Nordic countries. It was processed in the Nordic Council Session 2019 on Wednesday 30th of October. All members (70/70) of the Nordic Council voted in favour of the proposal, stating that the Nordic Council strongly advices the Swedish and Norwegian governments to work towards regulating osteopathy in their respective countries.

As many of you know, osteopathy became a regulated health care profession in Denmark last year in July. Currently there is an ongoing process, with more and more Danish osteopaths being accepted by the regulating authorities. Osteopathy is now an officially regulated and recognized health care profession in three out of five Nordic countries; Iceland, Finland and Denmark.
The Nordic osteopathic community is growing! Altogether, in the five associations, we are now approximately 1140 osteopaths. As a united profession in the Nordic, we have a stronger position to be able to reach our goals and missions. Together we are stronger!

The very first Nordic Osteopathic Congress (NOC) was launched last year in Oslo, Norway. Earlier this autumn the second NOC went off in Göteborg, Sweden. Next year it will be in Helsinki, Finland, 2021 in Copenhagen, Denmark and 2022 in Reykjavík, Iceland. It would be great to see as many osteopaths as possible coming together during these conferences. We will continue to do our best to make these conventions a great happening and a learning experience.

The Nordic Osteopathic Alliance is the newly founded unity between the Nordic osteopathic associations. Please follow us on social media, as there will be more to share. The future for the osteopathic profession in the Nordic countries is bright!

Best wishes,
Haraldur, Hanna, Laura, Gudrun and Tomas

The Swedish CAM Inquiry

Text: *Luke Bennett Warner*

In April 2017 the Swedish government appointed an investigation into issues concerning care and treatment other than that conducted in established care. The inquiry was titled The CAM Inquiry, CAM being the abbreviation of Complementary and Alternative Medicine.

The inquiry had several goals:
· To review the Swedish law concerning CAM.
· To review current research and methods of evaluation around CAM.
· To develop a policy to introduce CAM methods into established healthcare.
· To improve contacts and understanding between established care and CAM providers.
· To deliver a system to present information about CAM that could aid patients in making more well informed choices.

Work with the inquiry was carried out by a team of medical- and legal professionals with a few representatives from complementary and alternative care that were mainly researchers. The first report was published in March 2019. Svenska Osteopatförbundet (SOF) has been in contact with different representatives of the inquiry during this process making sure that up to date and correct information was provided concerning Osteopathy.

The inquiry came to several conclusions and have made a number of proposals, the main points being:
· The Swedish National Board of Health and Welfare (Socialstyrelsen) shall produce unbiased information on CAM methods to be published online on 1177 vårdguiden, the main Swedish online healthcare portal.
· Increase knowledge of CAM for all healthcare professionals by including more information on CAM methods in all medical educations.
· The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) are to investigate which CAM methods that could be suitable to use within established care.
· A rework of Swedish law where treatment of serious disease is to be restricted to only practitioners within established care but to allow practitioners outside of established care to treat any patient group for symptom alleviation.

During this process SOF learned that the inquiry deemed osteopathy to be in a grey zone, legally considered a CAM method due to non-regulation but due to regulation in numerous countries around the world also belonging to established medicine. Osteopathy is mentioned in various places in the report, often in convergence with Chiropractic and Naprapathy, both regulated professions in Sweden.

SOF has composed and conveyed a formal answer to the report highlighting areas of concern, our main points being:
· We welcome the proposed changes to the law concerning treatment of serious disease and are glad to see possibilities for osteopaths to treat all ages for symptom alleviation.
· We welcome the proposal to inform the public about osteopathy through the government owned online portal but suggest strongly that SOF be a partner in producing this information, to ensure correct and updated information.
· We welcome the proposal to investigate the possibilities to include osteopathy within the established healthcare. Although we strongly reject any other profession than osteopaths with an approved education to deliver these services, in accordance with European standard EN16686 Osteopathic Healthcare Provision.

Working with this inquiry has been an interesting experience, especially in finding nuanced ways of communicating osteopathy and osteopathic education to government officials. Also having the chance to point out areas where osteopathy can really contribute and how far we as a profession have come, both as practitioners but also academically in Sweden and internationally. My belief is that this work has taken us another step forward for osteopathy becoming a natural part of established healthcare in Sweden.

Luke Bennett Warner
SOF Board Secretary / Osteopath

An Essay on Osteopathy: from Kirksville to Norway

Text: *Christian Fossum*

Osteopathic principles and practice grew out of the mind and experiences of American country doctor Andrew Taylor Still (1828 – 1917). Migrating from Virginia on the East coast of the US to the pioneering and developing parts of the rural Midwest, he started practicing as a physician in the early 1850s after completing his training as an apprentice with his father. This was much based on a rudimentary understanding of anatomy, physiology, pathology as well as the treatment of disease with experimental methods. His initial exposure to the practice of medicine was at the Wakarusa Mission in Kansas, the Indian reservation of the Shawnee tribe, which was followed by the settlement of the Still-Family in Baldwin, Kansas.

Still enlisted in the Civil War parting side with the Union States, where working at field hospitals he dealt with the casualties of war, their injuries and the complicating infectious diseases. Returning to his family homestead in Kansas in 1864, an epidemic of infectious disease swept the Midwest taking the life of three of his own children and an adopted one within just a few weeks. In his grievance and with his loss of confidence in the medical practice of the time because of its inability to save the life of his children, he gave up the practice of medicine. For a period of about ten years he occupied himself with arming, agriculture and inventing mechanical devices to make farm life easier. If he practiced any medicine at all in that period is not known. Still was also a well-read man, curious by nature, and may well have been influenced by knowledge from the intellectual matrix at the intersection of social, political, religious and medical, both orthodox and unorthodox, currents prominent in the mid-19th century US.

In the year of 1874 things did seem to come together for Still. There was a major shift in his thinking, probably as a result of all his experiences, thoughts and reflections, and new ideas were emerging. Combining his understanding of mechanics and pathology with the in-depth knowledge he had acquired in both descriptive and practical anatomy, he developed a embodied but at the same time physical understanding of how the body worked in health and diseases. Healthful functioning he reasoned, was based on the proper structural and functional integrity of the human body as a necessity for its ability to combat disease and illness through natural immunity. Therefore, any derangement in structure and function could potentially through the nervous system and impaired movement of body and tissue fluids lower the body ´s resistance to both further physical insult and disease. Thus, linking living anatomy with health and disease became the cornerstone of his concept. Subsequently, the Still considered palpatory diagnoses and manipulative techniques the most natural method of dealing with the body ´s structure and function and became the treatment method of choice. Over a period of two years, starting in 1874, he first developed the theories of osteopathy and then the practice, or how to apply it to patient care.

Initially when he presented his ideas to the academic and medical communities he was met with ridicule and resistance. The continued dominance and stronghold of heroic medicine which was based on bleeding, blistering and purging the body through blood-letting and calomel, gave little room for Still in spreading his early ideas of osteopathy. Despite the lack of an audience he continued to both practice and developing his theories, and by the early 1890s when he and his family had relocated to Kirksville, Missouri, he was so successful in practice that it was decided to start a school to impart this knowledge and these skills to others. The American School of Osteopathy was founded in 1892. This marks the professionalization of osteopathy as well as the first attempt at organizing palpatory diagnosis and manipulative therapy into a teachable system. The school quickly attracted students, not only from all over the States, but also internationally. And by the turn of the century, several of them had returned to Europe to establish practices, initially on the British Isles, and later in continental Europe. Osteopathy went global.

It may be important now to point out the two different trajectories in which osteopathy continued to develop. In the US in the 1920s the profession made a conscious decision to compete in the medical marketplace with medicine as opposed to chiropractic. As a result, all the Schools adopted the necessary curricula to train osteopaths to become physicians with full practice-rights. The last state to fully recognize osteopaths in the US as physicians with unlimited medical license was Mississippi in 1973. Today in the US, osteopaths constitute around 20% of the total physician workforce. Osteopathic medical schools shares major similarities in their educational structure to traditional medical schools, and after completing four years of osteopathic school they join the ACGME programs (Accreditation Council of Graduate Medical Education) together with the graduates of traditional medical schools to complete their internships and residency training towards their chosen speciality. Outside of the US, osteopathy as remained a lim-

ited-scope of practice profession as primary contacts but focusing more on traditional osteopathic principles, practices and methods as well as patient guidance and education within a biopsychosocial framework.
The first osteopathic school outside of the US was established as the British School of Osteopathy in 1917. By that time there had been such an influx on the British Isles of US trained osteopaths that it was decided to establish educational pathways in the UK. In years to follow, several schools and organizations of variable quality emerged in the UK and through its social acceptance the profession grew. Despite numerous attempts at securing statutory regulation for osteopathy as a profession, this did not happen until 1993 when the House of Lords passed the Osteopaths Act. The General Osteopathic Council was appointed by the Queen and the Privy Council to legally regulate the profession both for education and practice .

In the 1950s the first continental European osteopathic school opened in Paris. Established in 1957 this school offered part-time training in osteopathy for physiotherapists and medical doctors. Although a French operation, the teachers came mainly from the UK. Despite a turbulent decade after its establishment for legal and political reasons, this training model would from the 1970s to the 1990s spread throughout Europe and Scandinavia as a pathway to become an osteopath.

The first Norwegian osteopath was a woman. Siri Aaneland from Kristiansand travelled to America and graduated from the American School of Osteopathy in Kirksville in 1904. She was followed by her nephew, Knut Aaneland, who on her recommendations enrolled at the same school and graduated in 1930. He would return to Norway and set up practice in Kristiansand where he practiced until his death in 1999. At later dates Norwegians trained in the UK. Randi Ingeborg Vaagenes graduated from the British School of Osteopathy in 1958 with the prize as the best student. And others have followed her. Despite this, they have all remained fairly anonymous in the healthcare landscape of Norway.

Osteopathy also made an impact on manual therapy that developed as a speciality for physiotherapists in Scandinavia. Freddy Kaltenborn who was contributing in developing this, trained initially in orthopaedic medicine in London with physician James Cyriax. Subsequently he came in contact with osteopath and physician Alan Stoddard, who graduated from the British School of Osteopathy in 1935. He trained Kaltenborn in the specific joint assessment and manipulative techniques of osteopathy, which later adopted this in his teaching of manual therapy to physiotherapists. For early manual therapy this marked a shift away from the rather unspecific techniques of Cyriax towards a more specific approach.
In 1992 the first part-time training in osteopathy was established in Halden in Norway through the International Academy of Osteopathy from Belgium. In 1998 the Norwegian College of Osteopathy was established as a collaboration with the European School of Osteopathy (Maidstone, England), College International d Osteopathie (St. Etienne, France), College Osteopathique Francaise (Paris, France), and College Belge d Osteopathie (Bruxelles, Belgium). Now located in Oslo, the courses continued to be part-time training for physiotherapists and medical doctors, and the program was planned and overseen by the European School of Osteopathy with a teaching faculty supplied by all the four schools in the collaboration. Annual exams were held in France and the UK. The aim of the collaboration was to establish an independent, self-sufficient and autonomous school in Norway. By 2005 this was the case, and the Nordic Academy of Osteopathy became a reality. With less dependency on the collaboration, Norwegian osteopaths now conducted much of the teaching. The Nordic Academy of Osteopathy was also registered as a non-profit charity with one major objective: to establish a full-time government accredited education in osteopathy in Norway.

In 2008 the Academy opened its doors to its first cohort of fulltime students. And in the following years the number of students grew. The work towards government accreditation of the education continued, and in the process it was realized that the resources required for this was limited. A feasible next step would be to seek a partnership with a university or a university college. After a lengthy process, the Nordic Academy of Osteopathy merged with Kristiania University College in 2011, and became a part of what is now the School of Health Sciences at the Kristiania University College. The submission for government accreditation had started before the merger, and the osteopathic education was successfully accredited by the accrediting agency of the Norwegian government, NOKUT, in April 2012. On the international scene, the osteopathic program has a Memorandum of Agreement with the University College of Osteopathy in London (formerly the British School of Osteopathy), which was signed in 2010 to promote program, student and faculty exchange.

Today the osteopathic program is a part of Norwegian higher education as an integrated part of the School of Health Sciences at the Kristiania University College. It has a continued focus on teaching and health-services research, and utilizes an anatomy lab physiology lab and a student teaching clinic as a part of the education. The students are taught the basic medical sciences, medical sociology, health psychology, research methods in addition to the osteopathic topics ranging from osteopathic and healthcare philosophy, osteopathic principles and practice, clinical reasoning, osteopathic clinical approaches (symptom based management, minimalist and maximalist approaches) and a broad range of osteopathic techniques and management strategies. To aim of the program is to prepare the students and graduates as lifelong learners to be competent, safe and effective osteopaths.

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Christian Fossum
Academic, researcher and osteopath

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Regulation of osteopaths in Denmark

Text: *Hanna Tómasdóttir*

Osteopathy was officially recognised as a separate health profession in Denmark on 1 July 2018, after successful political lobbying by Danske Osteopater under the leadership of their President, Hanna Tómasdóttir and Vice President, Jannich Thomsen. The legislation on regulation of osteopaths was passed with the unanimous support of all members of the Danish Parliament, Folketinget, on 15 May 2018. Denmark thereby became the ninth country in Europe to obtain statutory regulation of the osteopathic profession, including protection of the title 'osteopath', ensuring both professional and educational standards.

Danske Osteopater is the largest professional association for osteopaths in Denmark, currently consisting of 201 osteopaths, and is the only organisation whose membership meets the educational standards eligible to obtain the government license to practise as an osteopath in Denmark. Over 90 percent of our members originated with a professional background as physiotherapists, who switched professions and studied osteopathy in a five year part time (Type II) D.O. training programme. Our Type I (full time educated) osteopaths, hold either a D.O., Bachelors or Masters degree in osteopathy, and are mainly educated from recognised educational institutions in the United Kingdom, with a few from Sweden. The majority of our members practise in the capital city, Copenhagen, but an increasing part of our membership are practicing osteopathy in Aarhus, Odense, and Aalborg amongst other cities. The gender distribution of our members is about 34% female and 66% male.

The Patient Safety Authority, a subdivision of the Ministry of Health, sets the educational standards for the profession, as described in the 'Executive Order on the Authorisation of Osteopaths'. The level of training is based on the WHO Benchmarks for Training in Osteopathy and the European CEN (Centre Européen de Normalisation) Standard for Osteopathic Healthcare Provision, with added elements (over those listed in the CEN Standard), and at a Bachelors degree level or equivalent, corresponding to level 6 of the European Qualifications Framework (EQF). The total amount of hours should be no less than 4,200, and includes 1,000 hours of supervised clinical practice (adopted from The WHO Benchmarks), for both Type I and Type II educated osteopaths.

Like the other 19 regulated health professions in Denmark, osteopaths must have an 'authorisation' or license to practise as an osteopath. The authorisations are issued by the Patient Safety Authority, and the title 'osteopath' is protected. However, during the transition period while the new legislation is being implemented, the osteopaths who were already practicing before the legislation start date, on 1 July 2018, are entitled to practise as osteopaths and use the title until the transition period ends on 30 June 2023, when all osteopaths will have to have obtained formal authorisation to practise as an osteopath. During this transition period, currently practicing osteopaths who do not meet the qualifying standards will have to study further to obtain the appropriate qualifications for authorisation, in order to practice as an osteopath after 30 June 2023.

As of 7 November 2019, 92 osteopaths have received their authorisation after being individually evaluated by the Patient Safety Authority.

Empress,
Hanna Tómasdóttir

Hanna Tómasdóttir
Leader of the Danish Osteopathic assosiation

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Impressions from the Nordic Osteopathic Congress 2019

Text: *Caroline Frost*

It started with a sudden flash of inspiration at the end of last year. What if we could also host a Nordic Osteopathic Congress? Norway had set the standard in 2018 with the historic first Nordic congress.

The concept for the Congress was to have a gathering of Osteopaths from Denmark, Finland, Iceland, Norway and Sweden and concentrate on a topic relevant to osteopathy. Could we do the same? Would it work? What would the theme be? Gudrun Göransson, our enthusiastic and courageous Chairperson was all in from the beginning. YES! It will be a great opportunity for the Nordic Region to cooperate and collaborate and for us to weave together research, clinical experience, and contribute to ensuring osteopathy keeps growing and developing.

As treasurer I took a little more convincing. Would anyone come? How about all the time and resources that would be involved? But very soon even I melted. The theme was decided ´The Body, The Mind and The Brain´ and we were off.

What is the neuroscientific mechanism behind the effectiveness of our osteopathic touch? How do we as osteopaths avoid burning out after five years in practice? Why do some patients understand themselves and what they need so much better than others? What is Interoceptive accuracy? How is evidence-based practice relevant and applicable for us? What do we do if a patient starts crying during a consultation? Do we talk to our patients about possible emotional treatment reactions? What is the most helpful way to communicate with patients in clinic?

The day started with Hazel Mansfield (Osteopath and lecturer) giving us an introduction to interoception. After a formative early start in the early 1900s there has been little research or interest in this area until an exponential explosion in the last twenty years headed by functional neuroanatomist Bud Craig. Interoception is one of three types of afferent, sensory information streams reaching the central nervous system: the other two being exteroception (sensation from stimuli originating outside of the body such as skin pressure receptors and vision) and proprioception (sensation from the locomotor system giving information around posture and movement).

What then is interoception? Interoception is the sense of the internal physiological state of the internal body at any given moment like knowing if we are thirsty, or in need of the toilet, and includes even an awareness of our feelings and the ability to have emotional control of them. It may then be a component that contributes to a sense of self/agency/consciousness. The function of interoception is both to regulate homeostasis as well as provide awareness of the internal state.

The integration hub or primary cortex of interoception is the Insula. The posterior insula controls awareness of things like how full our stomach is or whether there is a cool sensation on the back of our hand. The mid-insular controls attention and cognitive integration while the anterior insula controls feelings like empathy and compassion.

The degree of interoception we have, our interoceptive accuracy, has been shown to be associated with a very broad number of behavioural, cognitive, motivational and emotional aspects which are relevant to patients we see in osteopathic clinic. This includes control of emotions, accuracy of body image, panic and anxiety disorders and responses to acute and chronic pain. In our initial osteopathic assessment we can observe both the subjective state of our patient for example their emotional state, the words they use and also their objective state; are their pupils dilated, is their skin dry and pale. This can then help us decide whether treatment should include modalities that encourage an increase in interoceptive awareness or whether that may aggravate the patient and should be avoided, with a more exteroceptive approach being preferable. Visceral techniques and those involving affective touch may stimulate interoceptive pathways. Techniques involving movement and breathing techniques can also be executed in a way that encourages interoceptive inputs. Taking into account interoception will also affect the advice we give to our patients. We can recommend sport and mindfulness, meditation and interoceptive training, or recommend traditional movement-based therapies that have a think-feel-sense-move approach such as Feldenkrais, Tai Chi and Jui Jitsu. And we can inform patients that they may have a treatment reaction not only physically but also emotionally for a couple of days after treatment, if techniques that knowingly involve interoception have been used.

Robert Shaw (Osteopath with a PhD in psychotherapy) highlighted how neuroscience allows us to understand osteopathy and how helpful cross-professional interaction is for us. Specifically, he talked about how to protect ourselves as osteopaths from burn-out and he introduced us to aspects of working with psychological trauma in osteopathic practice. To start with Bob focused on ACE- Adverse

Childhood Experience. Adverse Childhood Experiences (ACE) refer to some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community and collective violence.

It has been shown that considerable and prolonged stress in childhood can have lifelong consequences for a person's health and well-being. It can compromise functioning of the nervous and immune systems and can lead to serious problems such as ischaemic heart disease, autoimmune disease and musculoskeletal pain. Where there has been a background of trauma there is often associated symptoms of difficulty with sleeping, high startle response and difficulty concentrating. One sign in clinic that a patient may have had an ACE is that their case history is often fragmented and not fully coherent. Where ACE is present osteopathic treatment should be given with care, prioritising gentle

techniques. At the same time building up a positive therapeutic relationship can be very important for a patient with ACE and can lead to improvement in their autonomic nervous system.

It is also especially important to encourage patients with ACE to get enough sleep and physical activity. A combination of a ´bottom-up´ approach of Osteopathic Treatment combined with a ´top-dowń approach of things like Cognitive Behavioural Therapy and Yoga is often helpful. As a practitioner it is important to be clear with boundaries, confidentiality, to take our patients seriously, be aware that patients might have a hidden story, do not ignore patients tears, be kind and well- informed and provide a safe, secure and calm clinic environment.

Bob then talked about how to recognise the signs of early burn-out for osteopaths and how to avoid it. Osteopath attrition rates are highest after five years in practice and increase if Osteopaths work alone. Some general warning signs are compassion fatigue, exhaustion, anxiety and depression and cynicism. A list of burn-out signs for osteopaths include having to drag yourself to work, beginning your sessions early and finishing late, finding yourself repeating the same routine/treatment for many different patients, giving advice as a short cut to treating, dozing off or spacing out during treatments, noticing a decline in empathy and being relieved when clients cancel. To avoid burn-out it is important to keep boundaries clear, stick to the allotted appointment time, check your working hours/fees, diversify with things like teaching, research, and supervision, don't take work home, get therapy, have hobbies outside of work, meet up with friends and be physically active.

Tobias Sundberg was our next speaker. A researcher from Karolinska Institute, Sofiahemmet and University of Technology, Sydney. He is currently conducting research into manual medicine and evidence- based medicine. Tobias set the scene by describing how osteopathy is relevant for modern, integrative, health care.

Important milestones have been the 2003 World Health Organisation ´Benchmarks for training in Osteopathỳ and the 2015 European Standard (CEN standard) for Osteopathy which is an agreement between 33 European countries. The 2008 WHO Beijing declaration has also been pivotal. The declaration serves to promote the safe and effective use of traditional medicine, and to call on World Health Organisation Member States and other stakeholders to take steps to integrate Traditional Medicine /Complementary Alternative Medicine into national health systems.

Integrative Health is defined as emphasizing a holistic, patient-focused approach to health care and wellness- often including mental, emotional, functional, spiritual, social and community aspects- and treating the whole person rather than, for example, one organ system. It aims for well-coordinated care between different providers and institutions. One barrier to wider implementation of integrative health is the lack of randomised control trials so the role of Evidence Based Medicine for the future of integrative health care, including osteopathy is therefore crucial.

Tobias then presented some recent research including a systematic literature review `osteopathic care for spinal complaintś by Verhaeghe et. al. from 2018 which showed that there is some evidence to show that osteopathic care may be effective for people suffering from spinal complaints. The latest NICE guidelines 2016 for management of low back pain states that manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) can be considered for managing low back pain with or without sciatica, as part of a treatment package including exercise, with or without psychological therapy. This compares to a systematic review by Machado et al from 2017 which reported that paracetamol was ineffective for spinal pain and that NSAIDs had no more effect than placebo for spinal pain.

An article in The Lancet (2018) by Foster et al, recommends a biopsychosocial framework for treatment of low back pain with an emphasis on self-management, resumption of normal activities and exercise, reduced focus on spinal abnormalities, no initial pharmacological treatment and an integrated health approach.

Tobias also updated us on the latest research he is doing looking into Osteopaths attitudes towards evidence-based practice. So far, the results show that there is an overall positive attitude to Evidence based practice, Osteopaths long for more research about osteopathy even if they are seldom involved in research themselves and only feel moderately skilled in the area of evidence-based practice in clinic.

Osteopath Tom Eirik Bjorkli then gave us an introduction to ACT (Acceptance and Commitment Therapy) and how it can be a helpful tool for us in clinic. In a nutshell Act is not aiming to cure a symptom or pathology but is focussed on working with the consequences of having pain and how to increase psychological flexibility so that pain can be managed more easily. We can be so tangled up in fixing pain that we lose sight of other aspects of life. ACT is based on the biopsychosocial model and has been found to be effective in more than 200 randomised controlled trials. Long term pain affects all aspects of life and incurs personal and social costs as it limits both physical and social activity. ACT is based on increasing the degree of acceptance of our life situation and increasing meaning in life. Being open to our experience and choosing how we behave. It is also based on making a commitment to doing the things that make us thrive despite having pain so that pain doesn't become the dominate focus.

It can be helpful to use defusion where we help the patient realise that thoughts are temporary products of the mind that doń t have to be believed or responded to. Ideas

like `I have a weak and damaged back  can be changed to `I am having the thought that I have a weak and damaged back. I doń t need to believe that . The idea is not to supress thoughts but to accept them.

There are many different tools used by ACT and one tool is Relational Frame Theory. This theory looks at how the language we use effects our cognition. For example, it has been shown that if a practitioner (e.g. osteopath) uses the word ´chronic they will mean `long-term , but the patient will most likely understand it as ´this will never be better and will last for ever . In clinic it can be helpful to use simple clinical appraisal questions like; What do you think is the cause of your pain? What have you tried when you are in pain? How has that worked? What s it like for you? Are you open to something different?

Sunday morning and day two of our Congress started with an introduction to Compassion Focused Therapy by Gabriela Jones (Registered psychologist and lecturer at Gothenburg University) So what is Compassion? Compassion is being moved by suffering and being motivated to alleviate and prevent it. Compassion begins by approaching suffering rather than avoiding it and requires courage and kindness. Compassion Focused Therapy was developed by Paul Gilbert at Derby University and he raised the importance of having an even flow between self-compassion (ways of being helpful towards ourself) compassion to others (supporting others as best as we can on their journey) and compassion from others (being open to the helpfulness of others).

A balanced flow of compassion also helps balance the three affect regulator systems of drive and achievement, soothing and connection, and threat and protection. If, for example, the threat and protection system is much more activated than the soothing and connection system, the lack of balance can give rise to burn-out and depression. As osteopaths we will probably be good at compassion to others and may need to also focus on self-compassion and allowing compassion from others.

There are two exercises that we can do to help to balance the three-fold flow of compassion and balance our regulator systems. The first is to use the body to calm the mind. In this `spotlight exercisè we move our attention around our body as if we were sweeping a spotlight around to different areas. With curiosity and non-judgement, be aware of different parts of the body in turn; the feet, knees, pelvis, back, stomach, shoulders, arms, hands, head and face. Notice an area of specific tension and what it feels like. Then notice an area of the body that is calm and relaxed and allow our attention to rest there.

The second exercise is to use the mind to calm the body using the ´stone exercisé . We take a stone in our hand and imagine that it is a part of a much bigger mountain, that the mountain has been there for thousands of years and is stable and immoveable. We can imagine taking protection by the side of the mountain and resting against it and leaning against it and finding security there. Then we can imagine that we are also sitting like a mountain, secure and unshakeable.
It can be helpful to remember Aristotles advice that `the most important relationship we can have is the one you have with yourself. To know yourself you must spend time with yourself, you must not be afraid to be alone. Knowing yourself is the beginning of all wisdom .

After having been replenished by Gabrielas lecture we were ready to immerse ourselves into the neuroscience of touch. Helena Backlund Wasling (Neuroscientist from Gothenburg University and Sahlgrenska Academy) started by describing the importance of touch and the neuroscience behind touch. For osteopaths this is highly relevant research. Why is it that treatment can be experienced as so pleasurable by patients and can even make them feel better, more connected and less lonely? One reason is that pleasant touch, the positive affective component of touch, is thought to be conveyed via a group of unmyelinated, low-threshold mechanoreceptive afferents, known as C-tactile (CT) fibres. These fibres are optimally activated by gentle, slow, stroking touch, the kind of touch that can occur during osteopathic treatment.

Touch can be divided into two systems. The most well-researched and well known is that of the discriminatory system involving pressure/vibration, temperature, itch, and pain. Is sensation smooth, sticky or warm. The discriminatory system works when low threshold mechanoreceptors in the skin are triggered and myelinated, fast acting A fibres conduct those signals to the somatosensory cortex. This simple reflex arc allows for motor control. However, there is also a second `affectivè system which has been discovered more recently. It has been shown that skin is also innervated by a class of unmyelinated low-threshold mechanosensory nerves, C-tactile afferents (CT fibres), with a conduction velocity about 50 times slower than myelinated A afferents. CT fibres conduct signals to the insula, the prefrontal cortex, the anterior cingulate cortex, as well as portions of the temporal lobe. So, there is a rapid "first" touch system with a discriminative function and a slow "second" touch system with an affective function – giving rise to feelings of pleasure. The discovery of this second system has led to a reinterpretation of the role of touch in health and disease.

CT fibres fire optimally when the speed of stroking is 3 cm/ second and when the skin is at typical (neutral) skin temperature. CT fibres are found exclusively in hairy skin which means they are found all over the body except for the palms of the hands, the lips, under the eyelids and the soles of the feet. The hairiest place on the body? -the nose. Skin is our largest organ functioning not only as a protective barrier, a filter of UV light and a producer of vitamin D but also as a sensory organ.

Due to their response properties, CT fibres have been implicated in social bonding and affiliation. Touch fulfils a very important social function in promoting connectedness and building relationship and trust. Many studies have shown this, one being that if a waiter/ waitress at a restaurant lightly touches the shoulder or hand/finger of their guests they are much more likely to receive a tip than if there has not been any contact. The same has been found in libraries. If a librarian lightly touches the hand of the visitor borrowing a book, the visitor is much more likely to associate the library with positive feelings. Touch which activates CT fibres has also been shown to decrease heart rate in infants who have a fully developed CT system at birth, explaining why stroking infants has a calming effect. Even though A fibres (type II) that conduct pressure sensations decrease in efficiency after the age of 75 the CT system remains intact. Some research has shown that touch which triggers the CT system becomes even more pleasurable after the age of 75, emphasising the importance of touch as a way to reduce isolation and loneliness in the elderly. Helena reiterated the importance of touch as an essential part of our interconnectedness and survival and how we as caregivers can be an essential part of that.

Osteopath and chairperson of the Danish Osteopathic Association, Hanna Tomasdottir, was our final speaker and gave us an introduction to positive psychology. She emphasised the importance of empathy and how a helpful opening question to patients can simply be ` How can I help`? with research having shown that a positive therapeutic alliance with patients is of greater importance than which technique we use in terms of patient recovery rates. Hanna encouraged us to write down every evening for a week three things we had appreciated or felt gratitude for during the day. The positive effect of doing this exercise can be measured up to six months after having completed it. Hanna also raised the importance of person-centred communication which is comprised of listening to what the patient has to say, asking them questions and being sensitive to their emotional state. It is important to listen and understand the perspective of the patient, give the patients choice and help the patient have realistic expectations of treatment. It is important to look for the strengths of the patients and to show appreciation, support, helpfulness and approval. We ended our congress on an up note – reflecting back to our neighbouring colleague the strengths- like creativity, perspective, judgement, curiosity and honesty, that we could identify in them when they described a recent challenging situation that they had been involved in.

A really interesting wide-ranging Congress on ´The Body, The Mind and The Braiń . I can't wait for our next Nordic Osteopathic Congress in Finland November 2020.

Caroline Frost
Osteopath in Sweden

Make room for improvement

Text: *Øystein Tronstad*

As therapists we put a lot of effort into our training, techniques and treatments. But what about the space we create around our patients and their treatments?

Have you ever been to treatment and walked through a hallway that feels more like The Shining than a place of health? Sat and waited in a room stripped for life except for the 10 year old gossip magazines? Entered a room that feels like it was taken from the outlet corner at IKEA? In 1994 Stephen Porges introduced the Polyvagal Theory, which had implications for the study of stress, emotion, and social behaviour. He points out how the dorsal vagal system is tuned to listen out for danger. Does it not make sense to create a calming and peaceful experience far from the office stress so many of us endure?

– This is an overlooked piece of the puzzle. There are several studies that look into the interaction patient-therapist, but imagine how much that already happens before the patient even enters your treatment room. How they are being met is so important, says osteopath Sondre Horntvedt at Lindebergs in Munich.

The «spa» feeling

In 2015 they rebuilt their entire operation from reception to waiting room. They used a professional carpenter to get furniture fitted for their concept. Countless hours were spent on putting the right colours together, grinding and polishing, looking at fabric samples, painting and get the desired outcome.

– I still get feedback weekly from patients about how fantastic it is to come here. We aim to create a positive «break» from their everyday life. Their sense of wellbeing changes. The same for our employees, says Horntvedt and mentions patients with hectic schedules that just sit down in the waiting area and enjoy the peace a couple of minutes, before they head out to work again.

A holistic feeling

At Lindebergs you have osteopaths, physiotherapists and personal trainers. Regardless of what you are coming for you are greeted in a bright environment with a big smile, there are fresh flowers, decorations for you to rest your eyes on and a cup of freshly brewed cappuccino or tea to enjoy. Even the pillows are not randomly chosen. Horntvedt admits to have an above average interest in design and interior, but points out that you do not have to be an expert to create a good patient space, or spend tons of money.

– You can find good-looking things at IKEA and similar places, but it is the total package that makes the patient feel well. There is a trend here in Germany that more and more people are starting to invest more into their clinic. I have not lived in Norway for 20 years but my experience is that the clinics are a bit plainer. It is not just about having a fancy coffee maker or chandelier. Our industry can profit a lot on using technology in visualizing and explaining for the patients what we do for them. We use iPads and 3D anatomy to educate our patients and create a better understanding. It is all part of the five star service concept that we strive to live by.

Horntvedts advice is to find out if this is something you have an interest for and can do yourself. If not, reach out to friends that might help or consider using professionals. In Oslo we find KOI Fargestudio, the only Nordic multidisciplinary studio focusing on colour and interior design.

Colours and lightning

– We are creatures of the forest where green is the natural tone, and colours are vital for our survival. Like we can understand that a red mushroom is toxic. Now the grey trend has come upon us in everything from cars to clothing. See the modern architecture in Bjørvika. White, grey and black. Think of a lifeless forest. If we come upon grey trees we know it is not life there, says colour designer and interior architect Sarah Leszinski at KOI.

There exists an own psychological torture method called white torture where you are robbed for stimulation and input. It gained newly publicity with the Guantanamo scandal in the beginning of the 2000s. Is it not ironic how a lot of workspaces, schools, hospitals and health institutions are so clean and white looking?

– The problem with white is that it reflects light and makes you tired. As humans we are never so far from our natural condition as in a white office with green light. Add that to the fact that we have cold, blue light 60 percent of the year here north. There is a thin line between calming and depressing. Lightning is equally important, says Leszinski who recently assisted a general practitioner in choosing colours, textiles and furniture for the waiting room.

Integration is key

In the British 2004 report «Lighting and colour for hospital design» the authors write «a properly designed visual environment, with the appropriate use of colour and lighting, will have important benefits in hospitals. A relatively small investment in good, thoughtful colour and lighting design may reap major dividends over many years for patients, staff and visitors.» With that knowledge, how do we proceed when our profession is osteopathy and not colour experts? There is a jungle where we react differently to colours based on personal taste, trends and culture. White can make us restless and anxious, grey can be depressive, black is often associated with grief and death, red with blood. Leszinski has one main lesson for us.

– «A single colour is no colour». It is not an isolated colour that matters, but how they all are put together, she highlights.
– I would say avoid too many saturated and really strong colours though. Remember, colours are there to make the waiting and treatment room a better place to be, and help the users feel safe and well. Subdued, quiet colours are usually good. Blue, green, wood, get some textiles on the chairs, you can paint the doors so that they highlight where the patients are going. Dare to play around with it. The big problem with colours today is the lack of colour in our society, she counsels and tells about a project in Norway where KOI redesigned a receiving space for children of sexual abuse. After they created a friendly atmosphere it has not happened again that a child has not wanted to enter the space.

What patients do you have?

If you are working a lot with specific patient groups like geriatrics or pediatrics it might be an idea to think about how the different groups could benefit from customized colour schemes.

– It is generally sad to see how many elderly institutions are almost without sensory stimulation. As we get older we lose the ability to see colours and are in need of stronger tones. Children on the other hand usually benefit from more mute colours so they do not get overstimulated. This is usually the other way around in our society.

Sarah Leszinski: Colour designer and interior architect at KOI.

Recommended reading:

Johann Wolfgang von Goethe
- Theory of Colours

Dr. Stephen Porges
- The Polyvagal Theory

Karl Ryberg
- Living Light: On the Origin of Colours

Hilary Dalke, Paul J Littlefair, David L Loe, N Camgöz - Lighting and colour for hospital design

Øystein Tronstad
Osteopathy student and journalist in Norway

Jane Nind a true pioneer in Osteopathy in Denmark

Text: *Jane Nind / Anni Bach Zangenberg*

Jane Nind was one of the first osteopaths in Denmark. She received her Diploma in Osteopathy in 1987 from The British School of Osteopathy. Jane was one of the founders of the Registered Osteopaths in Denmark/ Danske Osteopater and she is still working full-time in her own osteopathic practise. Read about her story, from wishing to become a Bio-engineer to be educated as an osteopath and from living in England to end up in Denmark. She describes the legislation process in England compared to the authorisation process in Denmark. Finally, she tells us about the first international cooperation and the future of osteopathy.

Jane´s background

Steen Steffensen and I studied at the British School of Osteopathy (BSO), Suffolk Street, London, where there were approximately 100 students starting each year.
We were awarded our Diploma in Osteopathy after the four year, full-time course, myself in 1987 and Steen one year later. Steen also received the coveted prize, two years running, for excellence in Osteopathic Technique.

Having satisfied the examiners in all the academic subjects and our mastery of manual techniques, we were then rigorously evaluated in our clinical competence and suitability as future osteopathic practitioners. Our clinical experience, about 2000 hours, took place in the School s adjacent Clinic where we worked in 8 teams, supervised by clinical tutors, initially as observers, but by the 3rd and 4th year with increasing responsibility for planning and execution of patient treatment.

During the first 18 months, the basic science course, the emphasis was on in-depth anatomy, myology, arthrology, osteology, embryology, physiology, and an introduction to osteopathic techniques and diagnosis. Our teaching team included doctors and senior osteopaths. We had to show our proficiency in all subjects to be allowed to continue.

The pre-clinical course following developed our knowledge of the theory and practice of manipulative procedures, Osteopathic diagnosis, Principles of Osteopathy, including an introduction to pathology. Our studies continued, including clinical psychology, nutrition, more anatomy and pathology.

The clinical course, until the end of the fourth year, included clinical methods, osteopathic principles and diagnosis, pathology, applied anatomy and physiology, technique and applied technique. We also had the opportunity to participate in special clinics at the BSO, for example Antenatal -, Sports-, Children's Clinics as well as attend dissection at St. Thomaś s Hospital.
We were taught Osteopathic technique by a great team – Laurie Hartmann, Clive Standon and David Tatton. We were privileged to hear lectures by the previous principal Colin Dove and visiting Professor Irvin Korr, two wonderful speakers, to meet Jocelyn Proby in our clinic and have Steve Sandler and Steven Tyreman as tutors, all now historic figures in Osteopathy.

After we received our Diploma, presented by HRH The Princess Anne, and passed our clinic competence assessment, we could apply for membership of the Register of Osteopaths. Our certificates could be displayed on the wall in our future clinics.

Why did she choose osteopathy?

My career choice at 18yrs was to become a Bio-engineer. There was no direct route in 1968. Some years later, after travelling, and 10 years of headache and migraine, I was inspired to consider a new route, after successful treatment from Osteopath Stephen Pirie, Marylebone Road, Central London. After an interview with Audrey Smith, I secured a place at the BSO and my new life began.

Steen, working as a physiotherapist in Denmark and the Faroe Islands, was very impressed by the Osteopathic techniques presented by John Blackman and his team, MOBS course for physiotherapists, and decided to travel to London to take the full Osteopathic qualification.

Steen Steffensen & Jane Nind

For both Steen and myself, we admire Osteopathy for:
- the practical and technical accomplishment.
- it works – promoting the bodý s self-healing capacity.
- a profession where one is self-employed and independent.
- the high level of medical disciplines.
- the communication, through touch, between Osteopath and patient.

Personally, it has given me a new life, a network of good colleagues, a livelihood,
the possibility of moving to Denmark, my marriage to Steen and gaining Danish citizenship in my own right, as a working Osteopath.

Still working full time 31 years later, Osteopathy fills 14 hours of my day, including clinic hours and paperwork Monday to Friday.

Coming to Denmark

Since discovering that my family name had roots in Scandinavia and spending the summer of 1966 as a teenager in Copenhagen, I had the dream that one day I could become a Viking! Having fallen in love with a Dane in London, and being invited to join him to start an Osteopathic practice in Denmark, made my dream come true. For us both, it was an exciting adventure, the challenge of being pioneers.

Steen and I arrived on Sankt Hans Aften 1988, flying over bonfires on the beaches, looking forward to moving into our new house in Slagelse. The house included an existing physiotherapy clinic, which we had planned to develop as a combined osteopathic and physiotherapy practice. As a condition of the purchase, Steen had arranged that the outgoing physiotherapist would arrange a meeting with all the towń s doctors, where we could present Osteopathy. This proved to be a valuable start; we were well received.

We believe that we were the first Registered Osteopaths practicing in Denmark.
At that time, there was no Internet, only the Reference Library and telephone books. The librarian in Slagelse helped us with extensive searching for any leads to other Osteopaths in the country. Her conclusion was that there was no trace, that we would have choose how to spell Osteopathy in Danish, as it didń t exist! We chose "Osteopati" and opened our clinic a month later, after remodelling and repainting the treatment rooms – we had begun.

From the start, because Steen is a Danish Physiotherapist and the clinic was registered with its –yder-number, there was a regular stream of patients from the local doctors. His extra qualification and capability in Osteopathy techniques and diagnosis was attractive to both practitioners and patients. For myself, not being included in the health service system, I chose to focus on the holistic side, with cranial, myo-fascial and functional technique. It was an uphill challenge when the qualification and the title were unknown and patients were used to health service discount for physiotherapy.

As the Clinic for Osteopathy and Physiotherapy became established, Steen was called in to a meeting with the Danish Physiotherapistś head office. They informed him that they would not accept that physiotherapy could be combined with, what they considered to be alternative, osteopathy. He had to choose how he would present himself – either a physiotherapist or an osteopath. He could not advertise or use both his titles together until many years later.

The foundation of Registered Osteopaths in Denmark/ Danske Osteopater

On the initiative, as I remember it, of Micala Bendix, Claudio Colombi and Jaron de Murashkin, the Association for Danish Osteopaths was formed in 1997, with Micala as chairman. I joined the group soon after, together with Birgit Taarnhøj. We five members met regularly at Micalá s clinic in Copenhagen, to establish our Articles of Association, ethical standards and how we could promote and safeguard the new profession of Osteopathy in Denmark. It was exciting to be the pioneers, supporting each other, not competing. We shared a background of being full-time qualified Osteopaths, from schools in London, Italy and New Zealand.

As time progressed, we were joined by others, having taken the route of Osteopathic extension courses over a physiotherapy qualification. The inspiration and energy level in the Association increased, with Uffe, Eivind, Henrik, Hans and more. We visited each others clinics and formed a lively network, gaining from each others experiences. We saw the dawn of Internet and Homepages, growing away from the yellow pages in the phone book, posters and pamphlets.

The structure of the Association developed rapidly as membership numbers increased. The Chairman and committee changed at intervals, to allow new energetic members to offer their input. The Annual General Meeting helps us maintain our network and an increasing number of courses are valuable for our professional development.

The professionalism of the Associatioń s committee in the recent years has been impressive, helping us achieve the goal of authorisation that we have sought for over 20 years.

The Authorisation Process in England and Denmark.

Osteopathy became the first complementary healthcare profession to be accorded statutory recognition in the United Kingdom, under the 1993 Osteopaths Act. The General Osteopathic Council (GOsC) was established and opened its statutory register of osteopaths in May 1998 and is responsible for regulating, promoting and developing the osteopathic profession. Since May 2000 it is an offence for anyone to describe themselves as osteopath and practice as such, unless registered with the GOsC.

All practicing osteopaths were required to apply for Registration with the General Osteopathic Council, to be included in the new register in 2000, a revalidation. The application procedure, called PPP (Professional Profile and Portfolio), was a huge undertaking. It was divided into 2 sections:
- Personal and practice profile: containing a detailed description of the pattern in ones practice life, current skills, personal assessment of education and training, reflections on ones experience in osteopathic practice, development activities, typical working week including number of patients seen.
- Professional portfolio: self-assessment of ones clinic competence and safety, osteopathic management of a patient (with full case reports from several patients), and self-assessment of ones osteopathic skills.

Having been accepted on the new register, you received a certificate valid for one year. To continue your registration, you had to justify 30 hours of CPDO (Continuing Professional Development) each year and prove valid insurance.

By comparison, the authorisation process here in Denmark, has been much less arduous, only involving presentation and validation of education and work experience.

The international cooperation and the future for our profession.

The first meeting of the Forum for Osteopathic Regulation in Europe (F.O.R.E.) took place in the preserved historical building "The Royal College of Physicians", London, in 2005, planned by GOsC to facilitate discussion amongst European osteopathic organisations. I represented the Danish Osteopathic Association. We sat around the large "horse-shoe" table in the assembly room with 34 participants representing 15 European countries. After the introductory speeches, presentations and following group discussions, the representatives from Norway, Sweden and Finland expressed a wish to form a Scandinavian group with the Danish association. One representative felt that throughout Europe we were already too fractionated and need to work together, rather than form yet more small groups.

F.O.R.E. had been proposed as a possible forum, to facilitate information exchange, to agree on training standards, a common platform from which the profession of Osteopathy can deliver high standards of care, ensuring patient safety. Representatives from the GOsC, EFO, EOU were present.
In conclusion there was an unanimous wish to continue cooperation, with common standards as top priority. A very significant meeting – split fractions all with a common end goal, valuable to contact other associations, comforting to have their moral support and experience, stimulating to feel their energy in the fight to gain Osteopathic recognition throughout Europe.
Since then, so much further work has continued to lift awareness, credibility and respect for Osteopathy in Denmark, at the same time developing strong international communication to other European countries – the way forward to the future.

Jane Nind
Osteopath D.O M.R.O.DK

Anni Bach Zangenberg
Osteopath D.O. M.R.O.DK in Denmark

FAGDAG I TRONDHEIM
NORSK OSTEOPATFORBUND

Rosenborg er Norges største fotballklubb. De har en lang og stolt historie, og et stappfullt premieskap. Derfor er det ekstra interessant at klubben også har fire osteopater i stallen.

To følger opp de unge lovende, og to er en del av det medisinske apparatet rundt a-laget. Haakon Schwabe og Christian Thorbjørnsen har til sammen rundt 40 års erfaring i toppfotballen - nå har de sagt seg villige til å dele sine erfaringer med oss.

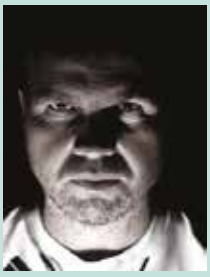

Foto: Nordskog

Tematikk: Idrettsmedisin og behandlerens rolle i lagidrett, med fokus på egne erfaringer i toppidretten.

- Hvilke mekanismer du må forholde deg til i en fotballklubb.
- Press fra omgivelsene: spilleren, trenere, fans og media.
- Skadeforebygging og rehabiliteringens ulike faser.

Lunsj og kaffe er inkludert.

Omvisning på Lerkendal Stadion.

Middag etter fagdagen er inkludert (eksl. drikke), og avholdes i toppetasjen på Scandic Lerkendal.

Dato: **8. februar 2020** | Tid: **kl.11.30-17.30** | Sted: **Scandic Lerkendal** | Pris: **2 000,-**

Measuring outcome in osteopathic practice

Text: Carol Ann Fawkes

More than 150 years ago, Florence Nightingale reported that patients left her care either "dead, relieved, or unrelieved"[1].

In spite of the intervening passage of time, many healthcare systems have continued only to collect routine data concerning whether patients leave hospital dead or alive, but have focussed few resources on the assessment of delivery of care and its quality[2]. Many clinicians from all clinical backgrounds will share the view that mortality statistics alone are an imprecise and perhaps inappropriate statistic to measure success in many conditions[3,4]. This article considers the background to the collection of outcome data, how it fits into an osteopathic setting, data collection initiatives in United Kingdom (UK) osteopathy, and the challenges and rewards of collecting outcome data from patients.

Background

Ongoing quality assessment is an implicit part of good patient care, and this can be achieved in many ways. The manner in which the quality of patient care is assessed depends as much on clinically-led initiatives as on political and organisational changes introduced.

Historically quality assessment has been through monitoring of scientific measures e.g. clinical tests; clinical audit; and ongoing data collection. More recent changes have focussed on the introduction of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs). Nationally and internationally there is an increasing focus in healthcare and among other service providers on collection of outcome data. In some instances the level of data collection and retention is both overwhelming and superfluous; for some individuals this widespread data collection and its distribution is a cause for concern especially when related to personal information. The drive to measure outcomes of care is no less relevant to osteopathic practice as to any other discipline or healthcare system. The growth of an evidence informed culture in healthcare has been notable in the past decade. Government bodies and private health insurers increasingly require evidence before considering the funding of care including osteopathy. Meeting the demands of an evidence-informed culture represents both challenges and opportunities for osteopaths and their patients.

What are PROMs?

Although the term patient reported outcome measure, or PROM, is being used increasingly, it is important to be clear about its meaning and potential application to patient care. Patrick et al. described PROMs as "reports coming directly from patients about how they feel or function in relation to a health condition and its therapy without interpretation by healthcare professionals or anyone else"[5].

A PROM is essentially a form of questionnaire to measure a patient's health status. In osteopathic practice that measurement might include pain, disability, quality of life, fatigue or satisfaction: the key point is that this measure is from the patient's perspective rather than from an osteopath or any other clinician.

Why are PROMs important?

The use of PROMs has grown substantially in the UK within the past decade, but earlier international work in mainland Europe and North America is notable. In the USA, the National Institute for Health (NIH) allocated funding for the creation of the Patient Reported Outcome Measure Information Service (PROMIS) database.

The impetus for developing patient-focussed initiatives began originally in the 1970s; principally in the USA. This occurred due to government support and an increased interest in the quality of medical care6. The Griffiths report (1983) encouraged the role of the consumer as a legitimate judge of quality and called for measurement of levels of satisfaction through patient surveys[7,8]. There has been an increased shift in consumerism and a consumer-orientated culture in healthcare in the interests of maintaining a competitive edge9,10; the term consumer has appeared increasingly in patient satisfaction literature[11,12,13,14]. Thompson described prevailing models of patient involvement in care and the consequent shift in the balance of power between patient and clinician:

- parentalism (involvement limited to receiving information or giving consent);
- shared decision-making (options are shared between patient and practitioner);
- practitioner-as-agent (practitioner holds technical expertise, but patient preferences are incorporated into decision-making);
- informed decision-making (technical expertise transferred to patient who makes the final decision)[15].

Such notions have proved challenging to many established cultures in global healthcare, with "recognition of the patient as a stakeholder rather than a grateful recipient in the provision of healthcare" requiring adjustment to both the process and environment of service delivery16. There is, however, a contrast between publicly-funded e.g. the UK National Health Service (NHS) and private sector healthcare; however Arnold and Weissman noted that "Patient power should be no more problematic within an NHS system than it is in a system of health provision in which the patient is a paying client"[16]. In a competitive market place it is imperative for private sector practitioners to recognise the power of patients as stakeholders and the potential impact their ideal, predicted or normative expectations, could have on business success[17].

Important things to consider when choosing a PROM in clinical practice

Although the use of PROMs in clinical practice is more recent they have been widely used for many years in research studies. Fitzpatrick et al. identified seven major types of instrument for patient reported outcome measurement including disease-specific, site-specific, dimension-specific, generic, summary item, individualised, and utility[18]. It is important to consider the purpose of using PROMs, the setting, and the patient population when making a decision about which PROM to use.

PROMs have their own characteristics known as measurement properties. Measurement properties relate to a collection of attributes within a measurement instrument. These can include the reliability of the measure, different aspects of validity, and the capacity of the instrument to detect change (responsiveness). These attributes are instrument-specific and will be informed by the context within which the instrument is used e.g. the population, clinical setting, and purpose for using the measurement instrument[19]. It is important when evaluating a PROM to consider the setting for which it was developed, the patient group for whom it was developed, and who was involved in its development e.g. clinicians only or patients and clinicians in addition to whether it demonstrates sound measurement properties.

Various groups use different terminologies to describe PROMs but the terminology more commonly used now is that advocated by the COnsensus-based Standards for the selection of health Measurement Instruments (COSMIN) group[20]. The different components of validity, reliability, responsiveness, and interpretability are represented visually by the COSMIN group for ease of understanding[21].

PROMs in osteopathic practice

Although clinical trials have been conducted where osteopathic care has been used, there is still little information about day-to-day osteopathic care and its outcomes. In 2009, the National Council for Osteopathic Research (NCOR) developed a standardised data collection (SDC) tool to collect prospective data about osteopathic practice[22,23,24]. This work has been replicated in other parts of the world[25-29]. The UK SDC study identified that a

facility was required to collect outcome data from patients independent to the clinician to achieve a robust dataset which reduced opportunity for bias.

The use of Patient Reported Outcome Measures (PROMs) to measure the effects of care is being advocated increasingly in clinical settings. Current patient data capture often involves completion of paper questionnaires which is costly and environmentally perplexing. New innovations are required to balance the challenges of introducing data capture directly from patients while considering budgets, access to Information Technology, and the capability to use technological devices. In response to this, NCOR developed a PROM data collection facility using a web and mobile app[30]. This facility is now implemented nationally in the UK, and is being used in a translated format by osteopaths in Belgium, France, Germany, and Switzerland. More osteopaths groups across Europe are becoming involved in PROM data collection and further cross-cultural translation and pilot testing will be taking place during 2020.

Barriers to PROMs use

Although there are many advantages to using PROM, some barriers have been identified in the literature. These barriers range from the practical e.g. concern about the potential disruption to normal practice, lack of confidence when using PROMs, and uncertainty about how to deal with data[31]. Systems are available which attempt to address some of these practical challenges ensuring that clinicians and their patients benefit from the documented effects PROMs can have on improving communication and compliance with treatment[30,32].

Using PROMs for benchmarking

Many osteopaths work in single-handed practices and it can be difficult to compare individual care performance to others unless national standards exist. Benchmarking our practice against that of colleagues can help identify where there is variation in outcome. This can identify potential opportunities for continuing professional development, and reflection on clinical practice.

Conclusions

The importance of asking our patients for their feedback on their management is not to be underestimated. The opportunity to gain robust input into the therapeutic process by patients is likely to increase their compliance and assure them that their involvement and feedback in their management is a vital part of osteopathic care. Although using PROMs in osteopathic care can present some challenges, these are by no means insurmountable; the benefits of being able to demonstrate objective findings based on patients' reports include developing a growing evidence base about osteopathic care.

Carol Ann Fawkes
Doctor of Philosophy

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Pain and mindset, something for you to explore?

Text: *Haraldur Magnússon*

Most people view pain as a result from tissue damage. You fall and hit yourself, meniscus in the knee is torn or a disc in your spine is herniated, and the intensity of the pain is in accordance to the level of tissue damage. But what most people fail to realise is that pain is heavily regulated by the pain system.

That explains why someone can have intense pain from a papercut while another person can feel no pain at all after losing a limb. The pain system can also continue giving messages of pain long after the tissue damage has healed. Even yet, there is no need for tissue damage in the first place for the pain system to give out pain!

Sadly, too many people that come to see therapists like osteopaths live with chronic pain. It can be fibromyalgia, it can be after exposure to molds, after a burnout, a chronic neck injury and many other reasons. What these problems all have in common is that they respond not well to manual treatment. Research is increasingly showing that the pain system in your central nervous system (i.e. your brain) can be the main reason behind chronic pain, hence the birth of the centralization pain theory. Several treatments have been found useful for either calming down the pain system or increasing pain coping skills such as mindfulness, positive psychology, cognitive behavioural therapy or Acceptance and commitment therapy as an example.

Whether you are a patient or an osteopath frustrated with lack of results I encourage you to explore the possibility of learning and using these different methods to combat chronic pain that hasn't responded to manual treatment.

A good place to start is the book Life After Pain by Jonathan and Naomi Kuttner (which I'm in no way affiliated with). I have had numerous clients that have found results by applying the methods described in the book.

Haraldur Magnússon
Osteopath and leader of the Icelandic Osteopathic Association

Report on the Nordic Council vote for the OIA

Text: *Laura Lee Kamppila*

The proposal for common authorization of osteopathy in the Nordic countries. In Helsinki, November 10th 2019

On the 30th of October the Nordic Council had its annual session in the Swedish Parliament in Stockholm, Sweden. The Nordic Council is the official body for formal interparliamentary co-operation. Formed in 1952, it has 87 members from Denmark, Finland, Iceland, Norway, the Faroe Islands, Greenland and Åland. From 29 to 31 October, politicians across the Nordic Region gathered for the 71st Session of the Nordic Council. The session is a Nordic summit and the largest political event of the year.

The climate, sustainability, and the involvement of young people all featured on the agenda. The vision of the Nordic Council is that the Nordic region will become the most sustainable and integrated region in the world by 2030. The Council does not have legislative power, but it does give strong recommendations and advice to national parliaments on proposals or subject that are voted on.

The presidents of the osteopathic associations of Denmark, Finland, Norway and Sweden got together on the 11.1.2019 to formalize their working together. During that day a visit was organized to the Danish Parliament, where a meeting with Liselott Blixt, a member of the parliament and chair of the Danish Health Commision, was held. As a result, a proposal was drafted for a common regulation throughout the Nordic countries by the presidents of Denmark, Finland, Iceland, Norway and Sweden.

This proposal was further discussed in the committee of culture of the Nordic Council in March 2019. The committee (composed of members of the parliament from all the Nordic countries) was unanimously recommending for the member's proposal for a joint Nordic authorization scheme for osteopaths, A 1808/culture, to advance for a vote during the Nordic Summit in October 2019. Each of the presidents of all the Nordic osteopathic associations were in contact with their members of the parliament that were going to be present in Stockholm for the vote to make sure they were aware of the importance of this process. On the 30.10.2019 in addition to presenting the proposal three speeches were made in favor of A 1808/kultur by Liselott Blixt and Henrik Moller, both Danish politicians and Kjell Arne Ottosson, a Swedish politician. 70 members were present during the vote and all of them voted in favor of the proposal!

This has resulted in a statement by the Nordic Council signed by the councils' president and secretary general that strongly recommends that the governments of both Norway and Sweden would proceed in regulating osteopathy as a health care profession in their countries. This statement is very meaningful and powerful for the Nordic countries and their co-operation, but also for the larger international community, setting an example of a region that can achieve a common regulation. Hopefully this can be an inspiration for the common regulation on a European level as well.

Laura Lee Kamppila
President of the Finnish Osteopathic Association

Osteopathy's way to the National Digital Patient Data Repository in Finland

Text: *Laura Lee Kamppila*

Health care professionals in Finland are entitled to save their digital patient notes into the National Digital Data Repository.

Developing the repository has been a long and slow government- initiated process, but by now it starts to be in wider use. The repository allows for the patients to have access to their own notes, but also (if authorized by the patient) for the other health care professionals to for instance share notes, test results and scan images. The electric prescriptions for medications are kept in the same repository.

Since some years, the Finnish government officials have expressed their desire for the private health care sector with its smaller companies to join the data repository as well. When the Finnish Osteopathic Association made an inquiry about the details of joining in 2016, the answer was that we were more than welcome to join, using either the nomenclature of the physiotherapists or the occupational therapists.

Following this proposal negotiations were launched for developing our very own nomenclature, more suited for the profession and describing what we do in our practices. The first meeting was held in June 2018, and the proposal for the creation of an osteopathic nomenclature was accepted in October 2018 by the Finnish institute of health and welfare (THL).

Glossaries and nomenclatures across the globe are all slightly different, and at first this task seemed like an impossible one. The association decided to start with a simple survey among the members to try and find and how people write down their patient notes and how they word them. Roughly around 10% of the members answered the survey, and their answers were used as a starting point for the procedure.

A panel of eight osteopaths together with a representative from the Institute of health and welfare started their time- consuming task. As there are three different schools for osteopathy in Finland, it was made sure that all three schools were aware of the process and they were offered the possibility to join the process. Eventually two terminologists joined the process, to ensure that the language used was correct, functional and not in conflict or confusing in relation to other nomenclatures already in use. As a basis, the CEN 16686, Benchmarks for training in osteopathy (WHO), Glossary of Osteopathic terminology (AACOM) and a thesis work from the Metropolia School of Applied Sciences was used. Different methods used in several schools were also looked at.

The nomenclature has a basic structure, set by structure and demands of the repository and of course the already existing ones by other professions. The format consists of titles and subtitles, that are arranges according to hierarchies. Different technics are not listed on the digital version, but different osteopathic approaches are present. The structure allows to describe the anamnesis, observation, palpation and testing as well as creating a treatment plan and the actual treatment. The titles have been chosen to best describe what happens during a consultation with an osteopath, but it also offers other titles for describing and classifying other types of work related to osteopathy or tasks performed by the osteopath, for example teaching, writing articles or doing research. It is designed to keep records of the whole scope of the profession, not just clinical work.

Initially the nomenclature was created in Finnish. Finland being a bilingual country by law, a Swedish language version will follow. Even though English is not an official language in the country, there will be an English version of the nomenclature as well. In the near future the association will be writing a guide book on how to use the terminology and a suggestion for a glossary of technics used by the osteopaths.

There is a written contract between the Finnish Osteopathic Association and the Institute of health and welfare, that states that the association is the owner of the nomenclature. As the repository is an initiative of the Finnish government, the entire process was free of cost for the association. The nomenclature is not set in stone either: in case within six months of a year there appears to be the need for change, it can be modified. The work needs to be done in accordance with the institute, it's terminologists and the panel approving on the entire nomenclature, but changes are possible. This is especially important in the beginning phases that the actual system is in use. It allows for the association to ask for feedback and user- experiences and develop the system accordingly.

Everyone writing their notes electronically has to use this system. There are some down sides to it as well. In addition to your payments to your regular data system provider, you pay a fee to the state for storing your information. There is some resistance to using a digital system all together. Like all new customs, this will take time to get use to. In the end it is believed that this form of patient notes will unify the profession, clarify what we do to the patients and reinforce the communication across health care professions.

Laura Lee Kamppila
President of the Finnish Osteopathic Association

Medial Tibial Stress Syndrome (MTSS)

Text: *Sævar Ingi Borgarsson*

Medial Tibial Stress Syndrome (MTSS), also known as shin splints is one of the most common lower leg injury. There is a consensus that MTSS is a bony overuse/overload stress reaction injury, a diffuse pain affecting along the distal 1/3 posteromedial or anteromedial border of the tibia.

Studies of MTSS treatment show no evidence of effect and treatments are based more on expert opinion rather than evidence. Most studies and opinions suggest cause to be more distal in the lower leg rather than more proximal in the lumbopelvic region and they endorse rest, ice, pain and NSAIĎ s, stretches, modifying training routine, strength training, quality footwear and orthotics, manual therapy, slow progressive training, extracorporeal shockwave therapy, acupuncture, injections and surgery if all other treatments are unsuccessful.

The spark for this study came from the author's anecdotal experience as a strength and conditioning coach and a student of osteopathy, encountering over dozen subjects complaining from a lower leg injury similar in characteristics of MTSS. Through assessment of each subject, the author repeatedly detected a pelvic region asymmetry. Following on the author used muscle energy technique (MET) via pelvis in the attempt to restore pelvic symmetry which had remarkable positive result on most of the subject's symptoms and in turn sparked the idea for this study.

The main purpose of this pilot study was to investigate and observe if there is a biomechanical link from the pelvic region, affecting or even causing MTSS, which can be corrected or reduced with MET treatment via pelvic region in general athletically active population.

This study was an observational pilot study of effect with non-control, non-randomization and non-blinding. The study spanned for total of 9 weeks. First, advertisement and recruitment for the study. After 4 weeks of recruitment, the first encounter (inclusion/exclusion interview, and measurement gathering). Second to fourth encounter, treatment and measurement gathering. The final encounter, measurement gathering. All encounters participated 7 days apart from each. Lastly, one month follow up via e-mail questionnaire.

The intervention technique was a MET technique via pubis symphysis, also known as the shotgun modality. This technique can have an effect on the whole pelvic girdle and the surrounding tissues. The subjects lay supine on a bench, with hip flexed approximately 45°and knees approximately 90°, with feet together on the table. From this position the practitioner held the knees together in a static position, while the subject tried to separate the knees laterally (horizontal abduction of the hip joint). The force of the practitioner and the subject was equal, relatively high and applied for 3-5 second, then relaxed and repeated for 5 repetitions. The same procedure was used in reverse for the adduction version of the technique, but with the starting position of the knees approximately 30-40° in horizontal abduction of the hip joint.

Primary measures for the result, showing the progression of symptoms, used visual analogue scale score for pain and quality of life score. The secondary measures were all bony landmark measures, recorded at all encounters, before and after treatment. The secondary measures were not statistically analysed for the result because of lack of time and resources. Secondary measurements measured symmetry/asymmetry at the pelvic crest, posterior superior iliac spine (PSIS), anterior superior iliac spine (ASIS), pubic symphysis (PS) and leg length test.

50 applications were received. 12 subjects were excluded, and 38 subjects included which finished the study. At the initial encounter/interview, all 38 (100%) participants had been symptomatic for at least 3 months or more. At final encounter, 17 participants (45%) were symptomatic, and 21 participants (55%) were asymptomatic. At one month follow up, 21 subjects (55%) were symptomatic and 17 subjects (45%) asymptomatic.

This study did not carry any evidence of effect because of significant limitations, with no control group, no randomization, and no blinding. The study's limitations will not be discussed in further details. All interested parties that want to get more information on the studies limitations, can send in inquiry and get a copy of the study.
It is well known among the MTSS population that MTSS can often appear suddenly, but also disappear suddenly, both without any sign or reason. What is the possible reason for that?

Structure governs function, is one of the pivotal principles in osteopathy. The posture is influenced by the gravitation, the habits we obtain, recreation, occupation where prolonged standing, sitting or certain position or repetitive movement is dominant for months and years. If the posture is relatively in line with gravity, then less stress is loaded on the body. Any aberration from normal will result in more stress on muscles, ligaments, joints, and tendons, which may result in tissue changes and a variety of postural adaptations. Changes in muscle length, strength and reflex, ligament tension, joint range of motion and/or fascial pull, will affect the function of tissues and structures. These changes can have a ripple effect like compensation, adaptation, asymmetry and alterations in the biomechanics that increases stress and load with variety of complications. With that in mind, isń t it safe to assume that this development is likely to affect circulation and lymphatic drainage and of course the bodý s self-healing mechanism?

Providing that with the existence of the aforementioned physical conditions, it seems reasonable to assume that inflammatory build-up from the biomechanical changes, coupled with the insufficient self-healing mechanism,

the structure and it s systems already striving to maintain homeostasis can be easily predisposed to injury like MTSS from the external environment e.g. habits, occupation and not to mention added repetitive physical activity/sports.

Could this be the answer to why MTSS can appear and disappear so swiftly? Then by balancing the body and therefore decreasing stress and normalizing the self-healing mechanism, inflammation decreases and symptoms reduce under pain threshold?
There were couple of interesting findings in the study which could support that the cause and effect of MTSS could be located more proximal rather than distal as most studies suggest.

Firstly, one of the inclusion/exclusion criteria were that if subjects had experienced low back pain any time during the last 3 months prior to the study they would be excluded. Surprisingly, all subjects except one had experienced low back pain during that period. With that in mind, this exclusion criteria was suspended from the study for it to be conducted. Could this finding suggest that cause and effect could be more proximal rather than distal?

Secondly, the high positive result from this study was not expected. Even though no evidence is to support this high positive result, it is nevertheless an interesting finding that could possibly indicate that MTSS could be caused more from the lumbopelvic region.

Even though these findings may indicate or support one theory over another one, it is important to reiterate that these are only interesting discoveries with no evidence to support.

The author ´s theory is that pelvic instability and asymmetry, coupled with abnormal internal rotation and adduction of the hip, internal rotation of tibia and subtalar pronation can flare up MTSS.
From clinical perspective, this trial aimed to correct pelvic imbalance, leg length discrepancy and restore the structure-function characteristics of the pelvis coupled with enhancement of the body's self-healing mechanism. To put it in another way, the osteopathic aim: find it, fix it and leave it alone.

This MET shotgun technique is simple and safe and possibly, this study could at least justify the inclusion of this technique into the treatment setting for MTSS to enhance the positive healing progression.

Finally, one should not forget rehabilitation and strength training, with focus on increased stability in the lumbopelvic region and slow load progression.

Sævar Ingi Borgarsson
Osteopath B.Sc in Iceland

Auditing process of Osteopatiakoulu Atlas

Text: *Tiina Lehmuskoski*

Osteopathy school Osteopatiakoulu Atlas has been educating healthcare professionals since 2008. From the beginning the school's core value has been to offer the best possible education to become an osteopath. Naturally everything started from small but every single part- from the curriculum to the teaching materials- was planned carefully as well as were the steps to how to achieve these goals.

Developing an education is a long-term work and the motivation for development comes from the fact that it has an effect in the larger scheme as well. Raising the school's own standards raises the level of osteopathy in Finland as a whole, makes osteopathy more known and helps in the legalization of the profession. In this perspective the European standardization and auditing came for a need and is a good tool to evaluate how Osteopatiakoulu Atlas has achieved its goals.

The auditing started in the spring of 2018 with the application and pre-work including documents. In August 2018 two auditors came to Osteopatiakoulu Atlas for two days to discuss with the administration, teachers and students. School's office was full of documents when auditors Marika Jevbratt and Jöry Powels were auditing. Auditors and school's principal Tiina Lehmuskoski had great discussion about teaching, examinations and developing the school's mode of operations. With good cooperation and reflecting different aspects Osteopatiakoulu Atlas got great ideas and tips on what to develop more and feedback on what is already on an excellent level.

After the auditing Osteopatiakoulu Atlas made a few changes in the educational programme and delivered the post-documents for the auditors. A couple of months after the actual auditing the school got the certificate of acceptance.

"Even though were are happy and proud to have the certification, we will still keep on developing the education and the status of osteopathy in Finland" says Tiina Lehmuskoski, who is also working as a member of the board of the Finnish Osteopathic Association.

Tiina Lehmuskoski
Principal of Osteopatiakoulu Atlas

Evidence-based osteopathy – is it even a thing?

Text: *Martin Stav Engedahl*

Is osteopathy an evidence-based profession? Are osteopaths really evidence-based practitioners? I want to answer yes to both questions. I know there are many osteopaths working hard to practice evidence-based. However, I also know that some osteopaths believe it is impossible to practice evidence-based and others might think they are practicing evidence-based without really doing so. How is that possible?

Let me start to explore my first question: Is osteopathy an evidence-based profession? Well, it depends. If we look at osteopathy specific research there are a few studies reporting good clinical outcomes for osteopathic treatment, especially for low back pain (1-3). Additionally, there are some osteopathic studies done on other disorders, for example headache (4-11) and neck pain (12-16). However, several of the studies conducted by osteopaths are pilot studies or randomised controlled trials with a small number of participants, a short follow-up time or with methodological limitations. Due to these limitations we cannot conclude whether the interventions are effective or not. If we look into osteopathic research with a critical view, we have robust evidence for good clinical outcomes for patients with acute and chronic low back pain (1-3). For other disorders we do not have enough or good enough research to claim that osteopathic treatment will favour a good clinical outcome. However, this is OK. Osteopathic research is still in its early years and the osteopathic profession is increasing its research competence and willing to conduct research. In the future there will be more clinical research from the osteopathic profession.

As osteopaths we are musculoskeletal practitioners. There are a lot of research done on management of musculoskeletal disorders. Clinical guidelines and consensus statements for several musculoskeletal disorders exists (17-28), and there are even webpages dedicated to make it easier for clinicians to practice evidence-based (29-31). As osteopaths we can utilise and integrate research done in the musculoskeletal field into our practice. Our patients are the same no matter who did the research. So, yes. Osteopathy is an evidence-based profession. However, it is up to the individual osteopath to choose to practice evidence-based.

So over to my next question: Are osteopaths really evidence-based practitioners? I claim to be an evidence-based osteopath. I know several osteopaths that are practicing evidence-based, and I know osteopaths that claim they are practicing evidence-based, but they are probably not. I have been told that it is impossible to practice evidence-based as an osteopath because we cannot do research on real osteopathic treatment or because it is too hard to keep up with the research. Well, it is partly true. It is hard to keep up with new research, and maybe we need to develop new research methods and designs supposedly more relevant for osteopathic practice. However, we cannot use those arguments to defend to not practice evidence-based. To answer my question, we need to understand what evidence-based practice is. Evidence-based practice is the integration of the best available research, our clinical expertise and experience with our patients believes and values (32). What does this mean? It means that we use our clinical expertise and experience to evaluate how we can integrate knowledge from the best available research along with our patients' expectations, goals, their history, allostatic load and values. We need to try to understand our patients' problems in the context of their lives. Only when we take the three elements of evidence-based practice into account, then we can say we are truly practicing evidence-based (33,34). How the three elements are weighted, however, depends on the individual patients.

Evidence-based practice does not mean that we follow prescriptions or rules on how to practice, or that we can find out how to treat our next patient by reading a research article (33). It also does not mean that we can say we have experienced that a certain treatment works and then use the same treatment on the next patient with the same problem without there being any research to support our treatment. Nor does it mean that we can use interventions only because our patients expect such interventions (34).

To summarise. Osteopathy is not a treatment. Osteopathy is a profession. A profession that utilises different interventions in the management plan and treatment for each and every individual patient. Osteopathy is not defined by which manual techniques we use. Osteopathy is defined by the way we understand our patients and their problems. Osteopaths can definitely be evidence-based practitioners. It's hard work. But it is our duty to offer the best possible treatment to our patients. If we want to be considered as a serious health profession, we need to practice evidence-based.

Martin Stav Engedahl
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NORGE P.P. PORTO BETALT

B

Siste nytt fra kurskommiteen

Tekst: *Jonas og Christoffer*

I forbindelse med fagdagen i november prøvde vi å arrangere en workshop den påfølgende søndagen. Formålet skulle være å samles for å utveksle teknikker og erfaringer rundt fagdagens tema; svimmelhet. Påmeldingene uteble, så arrangementet ble dessverre avlyst. Vi er noe usikre på akkurat hvorfor det ble sånn denne gangen, men vi prøver igjen neste gang også. Kanskje da med noe mer konkret opplegg, evt også en foreleser.

Uansett fikk vi ila fagdagshelgen spikret noen datoer for 2020, som det er verdt å merke seg. Som alltid vil offisiell invitasjon legges ut på Facebook, samt sendes på mail.
Påmelding gjøres via deltager.no

God jul fra
Jonas og Christofferi kurskomiteen!

Fagdag og kurs 2020

8. februar
Fagdag på Scandic Lerkendal med Christian Thorbjørnsen og Håkon Schwabe (Rosenborg)

14.-15. mars:
Fagdag på HK m/påfølgende kurs på Scandic Oslo City.

4.-5. september:
Pediatrikurs med Line Rølvaag på Scandic Oslo City.

Kommende aktiviteter

Idrettsmedisin og behandlerens rolle
Trondheim, 8. februar 2020

Fagdag og årsmøte
Oslo, 14. mars 2020

Oliver Thomson - "Words Matter"
Oslo, 15. mars 2020

Line Rølvaag - "Pediatri"
4.-5. september 2020

*Mer info kommer fortløpende

NORSK OSTEOPATFORBUND

HUSK DEADLINE FOR BIDRAG TIL OSTEOPATEN NR. 1/2020 22. JANUAR 2020.

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