3. THE PRACTICE OF OSTEOPATHY

3.1 Osteopaths are "allied health professionals"

In section 2.1, we described in general terms the nature of the osteopathic profession. It is now appropriate to place the profession within the family or group known broadly as the "allied health professions".

The concept of the allied health professional is familiar to health administrators. For a number of purposes, osteopaths are so regarded:

- It is one of the professions whose practitioners require registration and accreditation under State laws. Registration Boards operate in all States and Territories. The proposed National Scheme includes osteopaths as one of the 10 professions to be covered.
- Osteopathic services are likewise described as those of "allied health professionals" in the *Supplement to Medicare Benefits Schedule – Allied Health Services,* 1 November 2007. There is similar terminology in respect of Veterans' benefits.
- In the UK, the expression "non-medically qualified professionals" is used along with "allied health professionals" to describe nurses, chiropractors, physiotherapists, radiographers as well as osteopaths.[15]
- Under WorkSafe in Victoria (for example) injured workers seeking treatment for a work-related injury or illness are able to choose their own healthcare professional. However, only healthcare professionals registered with WorkSafe can receive payment for services. There are two types of healthcare services that WorkSafe can pay for, 'primary contact services' and 'referred services'. Osteopathy is one of the 'primary contact services' along with Chiropractic, Dental, Medical, Optometry, Physiotherapy and Podiatry. [16]

We do not know what enquiries the Productivity Commission made in reaching its definition of "health workforce professionals". For whatever reason (and none is given in the PC's report), osteopaths are not listed as one of the allied health professions it reviewed.[17]

In Australia, osteopaths must seek permission case by case to practice in hospitals (public or private) or nursing homes. Our Association is unaware of

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15 Royal College of Nursing et al, *Clinical imaging requests from non-medically qualified professionals* (2008).

16 WorkSafe Victoria, Introducing WorkSafe: A guide for allied healthcare professionals, July 2007, p. 5.

17 Productivity Commission *Research Report: Australia's health Workforce*, 21 December 2005, pp. 2-3. The Commission says:

"The study adopts an expansive definition of the health workforce, with the term 'health workforce professional" defined to cover 'the entire health professional workforce', from a number of education and training backgrounds, including vocational, tertiary, post-tertiary and clinical. Without attempting to be exhaustive, examples of relevant occupations covered include: doctors, nurses, midwives, physiotherapists, podiatrists, pharmacists, psychologists, occupational therapists, dentists, radiographers, optometrists, Aboriginal Health Workers, ambulance officers and paramedics. Generally, people must be registered before they can practise in most of these occupations."

Note that some of the groups listed by the PC are not included in the National Registration Scheme.

any blanket policy that would prohibit the practice of osteopathy in public hospitals. But it is fair to say it is unusual. Our experience is that liability and insurance issues loom rather larger in administrators' minds that any reservations about the clinical training or competence of qualified osteopaths. AOA proposes to work in the future to resolve or clarify these issues. In our minds, there is little doubt that the quality of healthcare for many would be enhanced, and the workload on our busy colleagues in other professions somewhat eased, if osteopaths had the right of practice in these institutions.

The word "allied" carries with it notions of alliance, cooperation and joint endeavours. AOA and its members see themselves as part of the range of professional health advisers and clinicians serving to advance the health and wellbeing of Australians. We seek to respect and cooperate fully with all others working for that same broad objective. Our clinical training and our professional ethics put the patient first.

In fact, this submission is about one practical, sensible way to enhance our capacity to co-operate fully and more effectively with other professionals (in this case, GPs, radiologists and pathologists).

In short AOA submits that the osteopathic profession is an increasingly relevant example of what the Minister for Health and Ageing has described as

> "the growing need for co-operation across different sectors of the health system, and of the truly 'mixed' nature of the health system that we now operate in"[18]

3.2 The profession of osteopathy

The Oxford English Dictionary defines osteopathy as:

> "a system of complementary medicine involving the treatment of medical disorders through the manipulation and massage of the skeleton and musculature".

In *Osteopathic Principles in Practice* Professors Kuchera give these definitions:

> "**Osteopathy**: Osteopathy is a total system of health care which professes and teaches the osteopathic philosophy:
>
> 1. The body is a unit.
> 2. It has its own self-protecting and –regulating mechanisms.
> 3. Structure and function are reciprocally interrelated.
> 4. Treatment considers the preceding three principles.

[18] Hon Nicola Roxon, Keynote address Australian Private Hospitals Association, 27 October 2008, pp. 4-5.

These four main principles of osteopathy are often called the four planks or tenets of the profession. Osteopathy also encompasses all recognised tools of diagnosis and healing including osteopathic palpatory and manipulative treatment methods. Manipulation is a tool used by the osteopathic physician to influence the patient's body function. The results can be observed and evaluated. Manipulation is not osteopathic philosophy and technically, it is not osteopathy.

Osteopathic medicine: "Osteopathic medicine is a medical philosophy that integrates medical, surgical and obstetrical care with the knowledge of the relationship of the musculoskeletal system to all other body systems in health and disease". To give this kind of care, the physician takes the clinical sciences (medicine, surgery, obstetrics, etc), applies the osteopathic philosophy and supports it with osteopathic principles (the scientific laws that support the osteopathic philosophy). The physician then treats the patient in a way which puts the osteopathic philosophy into action. Osteopathic medicine has been used loosely to mean any kind of care given by a physician who has graduated from an osteopathic college.

Art of practice: The art of practice is a physician's total and personal method of applying the scientific knowledge and osteopathic philosophy to the needs of the joints, fascias, lymphatics, autonomics, physiology, etc of a patient. The osteopathic physician takes his/her understanding and knowledge and considers medical and surgical knowledge is added: the physician then applies all of to the needs of the patient according to osteopathic principles regarding body unity and structure/function. This is provided for the patient through the physician's own personality and talent. The total presentation is called that physician's art of practice".[19]

In Australia, these principles find expression in the Accreditation Standards for tertiary institutions proposing to teach osteopathy. Standard 9 of these – the curriculum – says that it:

"is designed to achieve the goals of the course and includes instruction in:

(a) the basic sciences of biology, chemistry and physics to the extent necessary to lay foundations for proper understanding at an advanced level of the human and clinical sciences taught later in the course

(b) the life sciences of anatomy, histology, embryology, physiology, biomechanics, biochemistry, microbiology and psychology

(c) pathology, pharmacology and general medicine, especially those aspects of general medicine most important to osteopathic diagnosis and management, including especially the musculo-skeletal and connective tissue disorders and the neurological disorders

(d) critical analysis, problem solving, research methodology and biomedical statistics

[19] William A Kuchera and Michael L Kuchera, *Osteopathic Principles in Practice,* (1991), pp. 2-3.

(e) osteopathic science and the skills of osteopathic examination, diagnosis and treatment including the assessment and management of chronic disability and pain and how human behaviour, attitudes and lifestyle can contribute to illness and be factors in its amelioration

(f) the clinical skills of diagnosis, oral and written communication and counselling and the development of clinical judgement in deciding appropriate treatment and/or referral

(g) professional awareness including the history of osteopathy, ethics and the law as it relates to health care in general and osteopathy in particular, health care delivery systems in Australia and elsewhere, the means of and barriers to interprofessional cooperation, practice management and the means of ensuring continuing personal professional development through a career life".

These are spelt out more fully in Standard 11 – clinical training, reproduced at Attachment 1.

3.3 Osteopaths as providers of primary health care in the market for such services

The Government's Primary Care Strategy affects the operations of osteopaths intimately. Over 85% of our patients visit our clinics "off the street". That is, no more than 15% have been referred by a medically qualified professional.

Thus osteopaths are in the frontline in providing primary health care. As patients present for the first time, the osteopath must

- decide, using what diagnostic aids are available, whether the patient can, or should, be treated with osteopathic techniques;
- decide, in the case of a patient whom we assess as not amenable to osteopathic treatment, whether, and how, to refer that person to a medically qualified practitioner;
- decide, in any event, on what interim, immediate and/or longer term osteopathic treatment is appropriate to each patient.

AOA does not doubt that the very fast growth in demand and supply of osteopathic services arises from the operation of market forces. The people who seek us out, and/or have been referred, come to osteopathic clinics because they have a reasonable expectation that the services and care provided will be professional **and effective.** That is, the patient sees, and will see, that (s)he has received value for money. For this reason also, we see a great deal of return business, as well as word of mouth recommendations.

The market is working and demand for and satisfaction with osteopaths' services is high. These conclusions are borne out when you look at the financial details and growth projections provided above.[20] Only a very small

[20] See section 2.5.

proportion of gross fees earned by osteopaths are reimbursed. Even then much of that arises from private health insurance benefits.[21]

Moreover, as already noted, the profession of osteopathy is the fastest growing allied health professional group. This trend is expected to continue. The training and expertise of the Australian profession is very highly regarded overseas; indeed it is seen as a model by many.

The high level of respect for the profession has not been achieved accidentally, or as the result of advertising hype. Nor does it owe much, if anything, to public sources of healthcare funding. Our members' professional training and experience combine with high ethical standards to support and meet these patients' expectations.

Like so many healthcare modalities which do not follow orthodox doctor-based medicine, osteopathy operates successfully in the private health services market. Little or no public subsidies are available to those who choose to use our services. Yet they pay taxes. They pay the Medicare Levy, perhaps even at the penalty rate. Their choice to make use of osteopathic services has two important effects on the economics of the subsidised health services:

- pressure on these scarce and busy resources is relieved to the extent that osteopathy users substitute our services for those doctors might otherwise be asked to provide;
- secondly, and by the same token, our services tend not to be available – as we believe they should be – to people whose socio-economic status makes it difficult for them to access an osteopath.[22]

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21 See section 2.5.1 generally.

22 Two low-income groups who would likely benefit significantly from osteopathic services are seniors and Indigenous people.

In the case of seniors, there are a host of degenerative and painful conditions for which there is clinical proof that osteopathic procedures have been of significant benefit. Since the ETS began, there has been a steady shift upwards in the average age of osteopathic patients. This suggests that GPs do recognise the benefit to their elderly patients of osteopathic treatments, and/or that these elderly patients have perceived benefit from their osteopathic treatments.

In respect of Indigenous people, AOA strongly endorses the Government's objective to Close the Gap. Our professionals can play their part in this important national health objective. We recognise the issue of Aboriginal health as one with which osteopaths are not as familiar as we should be and would wish to confer closely with Indigenous leaders to work out culturally appropriate processes.

4. OSTEOPATHIC DIAGNOSIS

4.1 The nature and scope of diagnosis

As we have described above, the great majority of our patients come to osteopaths unreferred. That is, without any kind of triage that might help in deciding the patient's condition, or the treatment required.

Osteopathy is thus a "first contact" profession. Our scope of services makes this very clear.[23]

Such professional standing carries with it significant responsibilities:

- We must decide what treatment the patient needs.
- We must decide, then, whether it is within our scope of service to deliver that treatment.
- And we must decide, if that is not the case, what other professional attention should be recommended.

The process thus described is the same as that which a medically qualified practitioner would follow. In essence, it is the same a nurse or pharmacist will follow, or any other allied health professional with primary healthcare responsibilities.

A representative of AOA participated in drawing up the NHRMRC's paper, *Evidence-based Management of Acute Musculoskeletal Pain*. The principles and practices set out there are accepted by medically qualified professionals and osteopaths alike. That is, all concerned follow the same processes of assessment and management of patients' conditions.[24]

Our particular field of expertise is the musculo-skeletal system. We are trained and experienced to treat and help the patient manage a range of conditions arising from a less than optimal functioning of that system. We recognise, and have been trained to understand, that some conditions which patients perceive as appropriately treated by osteopaths may not be. For this reason, osteopaths are trained to look for conditions such as osteoporosis, osteopaenia, tumours, fractures, dislocations, infections and ligamentous tears. Once that pathology is discovered, we would expect then to refer them to their GP, or if appropriate, modify our treatment plan.

An osteopath's initial examination of a newly presenting patient will therefore follow well-understood diagnostic principles and procedures – well understood, that is, by medically qualified and professional osteopaths alike. Because our focus is the musculo-skeletal system, its functioning will be of first interest. As already noted, other pathologies may be observed, or

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23 The "Scope of Service" of Australian osteopaths is laid down by the various State or Territory Registration Boards, and there is some local variation. As well, various State statutes may permit or prohibit a variety of practices and these have relevance according to their tenor.

24 NHMRC, *Evidence-based Management of Acute Musculoskeletal Pain*, 2003. At p. 1, it is said that:

"Cochrane proposed the rationalisation of interventions (both diagnostic and therapeutic) to promote those with evidence of safety and effectiveness. To that end he suggested: promoting diagnostic tests likely to have a beneficial effect on prognosis, evaluating existing interventions to exclude those shown to be ineffective or dangerous, and determining the place of interventions when there is insufficient evidence of benefit."

suspected. Then, the normal range of diagnostic tools may need to be put to use, in order to understand as completely as possible what is, or may be, the patient's problem(s). Among these diagnostic tools are imaging and pathology tests.

In all cases, the health professional's role either is to give effect to the patient's expectation that (s)he can deal with their condition; or to find some other person who is better placed to do so.

Osteopaths do not claim to be experts or specialists in understanding or interpreting the results of a variety of imaging or pathology tests that our clinical judgement tells us a newly presenting patient might sometimes need. That is a matter for specialist radiologists or pathologists, as the case may be. What osteopaths are trained to do, however, is to understand the clinical situations where such expert advice may be needed, and, in the light of that advice, to take decisions in accordance with established clinical principles as to what is best for the patient going forward.

Students who are training to become osteopaths are instructed from the same teaching materials as those seeking to be qualified as medical practitioners. For example, Davidson's *Principles and Practice of Medicine* is closely followed, particularly part 20 – "Musculoskeletal Disorders".[25]

Similarly, students work with David J. Magee's *Orthopaedic Physical Assessment,* and, in particular, the "Principles and Concepts" in Chapter 1, which describes the proper procedures for patient examination when they present with an as yet undiagnosed musculoskeletal condition.[26]

Likewise, osteopaths must understand the appropriate procedures for assessing when diagnostic pathology is needed. In this respect, they follow the processes set out in John Murtagh, *General Practice*, and in particular Chapter 6 – "laboratory investigations". To quote Dr Murtagh:

> "Appropriate use of the laboratory, particularly the judicious selection of investigations, is an important skill for the general practitioner to perfect. It is wise to remember that the laboratory staff includes clinical pathologists, microbiologists and haematologists, who can offer invaluable assistance and advice. Hence, it is important to provide a properly collected specimen accompanied by a succinct and relevant clinical history ...
>
> It is advisable for practitioners to be conversant with the specificity and sensitivity of the various tests in order to make rational decisions about their interpretation and to provide appropriate counselling to their patients."

In the case of both imaging and pathology, osteopathic practice would not be to use these services as routine or regular. For example, our clinical practice does not require regular administration of an x-ray. Rather, we wish to have scope to exercise our judgement as occasion requires and for specific and identified situations as they present in consultations.

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25 19th Edn., pp. 957-1047.

26 4th Edn., pp. 1-6. The remainder of Prof. McGee's textbook is consulted as and when particular issues arise and students are required to understand the issues and procedures.

The present Medicare Benefits Schedule allows osteopaths to refer, for x-rays only, and only of the spine and related areas. **Such limitations are not clinically justified in the practice of osteopathy.** Patients will present with a range of conditions in a range of parts of the body. It is not efficient, from the viewpoint of either the patient or the clinician, that benefits are limited to a basically incorrect and limited view about how we work, and the scope of our practice.

Left hand: right hand (but only one is paying)

One of AOA members writes of his experience of Medicare bureaucratic constraints:

"I referred a patient to GP for US of both shoulders, as I often find that patients get tears in both shoulder tendons and it is prudent to check. The GP requested x-ray and US both shoulders. The radiographer told my patient that he can only have one shoulder done per day and booked them in on two days.

It appears that you can get x-rays of two regions on same day (Item # 57703) but Medicare won't pay for comparison. Invoice must say "left and right shoulder" or "not for comparison".

For US of shoulder or upper arm Medicare will pay for one shoulder only, whether one or both ultrasounded Item # 55808."

"Another patient was sent for a knee x-ray – suspected degeneration and cartilage height loss. The GP ordered one knee only, making the resulting x-rays very hard to compare with the other side.

"The reason for needing both sides when x-raying knees is due to the fundamental way we were taught to read and interpret them. I was taught by Dr Tom Molyneaux at RMIT. The process is as follows.

The A.B.C.S. approach. This method divides the process of film reviewing into four groups so that each is studied independently. The four groups are:

A Anatomy and alignment

B Bones

C Cartilage and joint spaces

S Soft tissues

Cartilage. At this time, the joint spaces are evaluated. There are many to examine so this is an important section. Forcing yourself to do this section will be very rewarding in the long term as joint changes (even complete dislocations) are often subtle and may be the only clue to the patient's underlying condition. Due consideration to patient positioning must be given here as this can significantly influence your decision as to whether joint space narrowing is present or absent. In examining the radiographic image of an articulation, the following must be considered:

i) joint space width (increased or decreased)

ii) articular surfaces (smooth, rough or hazy)

iiii) subarticular bone density (increased or decreased)

iv) calcification

v) intra-articular bodies

vi) joint capsule distension

vii) joint space density.

It becomes immediately obvious that your require both joints (especially knees) for comparison of joint space with. Without comparison you don't know if:

a) this is normal width/decreased or increased for this patient

b) changes diagnosis – is it degenerative change/wear and tear (one side,, asymmetrical) or is it Rheumatoid Arthritis (bilateral, symmetrical)

These experiences in daily osteopathic practice demonstrate how little the current Medicare Benefits Schedule has regard, if at all, to the proper clinical needs of osteopaths.

That incorrect and limited view may derive from official perceptions that there is little or no difference between the practices of osteopathy and chiropractic. We cannot speak for the latter, but the above general account of our profession's clinical training and practice shows that our interest is much broader than the spine alone — the whole person. In initial examinations leading to diagnosis, our focus is on the evidence, clinically obtained and without preconceptions or theoretical concepts alien to "evidence-based medicine".

4.2 Medicare benefits

The AOA submits that Medicare benefits should be available to patients of osteopaths in respect of pathology and diagnostic imaging services as if those services had been provided as a result of referral by a medically qualified practitioner. That is, our members' professional training and experience should be recognised as more than sufficient to enable the necessary clinical judgements to be made.

In the case of diagnostic imaging, the main services that would be referred, when clinical judgement so indicates, might include:

- *Plain film x-ray* – (of all areas) but especially of spine and peripheral limbs);
- *M.R.I* – soft tissue integrity for intervertebral disc, ligamentous, meniscal, tendon, bursa integrity;
- *Ultrasound* – soft tissue integrity especially for inguinal region, bursa, tendons (especially shoulder girdles) and visceral investigation and integrity;
- *C.T and Bone Scan* – to determine bone integrity including potential cancer, fracture or osteoporosis of a patient; and
- *Doppler imaging*.

In relation to *pathology services* osteopaths are interested in any conditions outside our scope of practice that may mask as a musculoskeletal condition, which may require referral to a specialist. These might include:

- *Thyroid function test*
- *Full blood examination*
- *Rheumatoid factors.*

In point of fact, osteopaths exercise their professional judgement to requisition any of the above diagnostic modalities. Apart from x-rays of the spine, etc, such referrals must either be paid in full by the patient or must be referred to a GP for on-referral, if Medicare benefits are to be claimed.

This process is wasteful – of our and GPs' professional time and of patients' and the Commonwealth's financial resources. It is double-doing. And it discounts osteopaths' professional integrity. For it rests on an assumption that our profession is not capable of exercising the professional judgements our patients expect and which our training demonstrably equips us to make.